



**U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Center for Medicare & Medicaid Innovation**

State Innovation Models:
Round Two of Funding for Design and Test Assistance

**Cooperative Agreement
Initial Announcement
Funding Opportunity Number: CMS-1G1-14-001
CFDA: 93.624**

Applicable Dates:

FOA Posting Date: May 22, 2014

Required Letter of Intent to Apply Due Dates:

Round Two Model Design: Due June 6, 2014
Round Two Model Test: Due June 6, 2014

Electronic Cooperative Agreement Application Due Dates:

Round Two Model Design: Due July 21, 2014, by 5:00 p.m., EDT
Round Two Model Test: Due July 21, 2014, by 5:00 p.m., EDT

Anticipated Notice of Cooperative Agreement Announcement Dates:

Round Two Model Design: October 31, 2014
Round Two Model Test: October 31, 2014

Anticipated Cooperative Agreement Period of Performance:

Round Two Model Design: January 1, 2015 to December 31, 2015
Round Two Model Test: January 1, 2015 to December 31, 2018 (Inclusive of a pre-implementation period of up to 12 months)

TABLE OF CONTENTS

OVERVIEW INFORMATION	1
I. FUNDING OPPORTUNITY DESCRIPTION	2
1. Purpose.....	2
2. Authority.....	2
3. Background.....	3
4. Proposal Requirements	3
5. Limitations on Design.....	14
6. Funding Restrictions.....	14
7. Requests for Data	15
8. Anticipated Substantial Involvement by CMS	15
9. Waivers for Models Conducted under SSA Section 1115A	15
II. AWARD INFORMATION.....	15
1. Total Funding.....	16
2. Award Amount	16
3. Anticipated Award Date	17
4. Period of Performance	17
5. Number of Awards.....	17
6. Type of Award	18
7. Termination of Award.....	18
III. ELIGIBILITY INFORMATION	18
1. Eligible Applicants	18
2. Cost Sharing or Matching Requirements.....	21
3. Foreign and International Organizations.....	21
4. Faith-Based Organizations	21
IV. APPLICATION AND SUBMISSION INFORMATION	21
1. Address to Request Application Materials.....	21
2. Content and Form of Application Submission.....	21
A. Letter of Intent to Apply.....	21
B. Application Materials	22
C. Format Requirements for Applications	25
D. Application Content and Structure.....	26
3. Submission Dates and Times.....	39

4. Intergovernmental Review	39
5. Funding Restrictions	40
V. APPLICATION REVIEW INFORMATION	40
1. Criteria.....	42
A. Model Test.....	42
B. Model Design.....	45
2. Review and Selection Process.....	47
VI. AWARD ADMINISTRATION INFORMATION.....	49
1. Award Notices	49
2. Administrative and National Policy Requirements.....	49
3. Terms and Conditions	50
4. Cooperative Agreement Terms and Conditions of Award	50
5. Reporting.....	53
A. Progress Reports	53
B. Project Monitoring.....	54
C. Evaluation.....	55
D. Evaluation Design and Data Collection	55
E. Monitoring and Rapid-Cycle Evaluation within States	57
F. Impact Evaluation	58
G. Federal Financial Report.....	59
H. Transparency Act Reporting Requirements	60
I. Audit Requirements	60
J. Payment Management Requirements.....	60
VII. AGENCY CONTACTS	61
1. Programmatic Contact Information.....	61
2. Administrative Questions	61
VIII. Appendices.....	62
Appendix 1: Plan for Improving Population Health	62
Appendix 2: Health Information Technology Plan.....	67
Appendix 3: Preparing a Budget Request and Narrative in Response to SF 424A	69
Appendix 4: Required Application Check-Off List.....	76

OVERVIEW INFORMATION

Federal Agency Name: United States Department of Health and Human Services
Centers for Medicare & Medicaid Services
Center for Medicare & Medicaid Innovation

Funding Opportunity Title: State Innovation Models: Round Two of Funding for Design and Test Assistance

Announcement Type: New

Funding Opportunity Number: CMS-1G1-14-001

Catalog of Federal Domestic Assistance (CFDA) Number: 93.624

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Round Two Model Design: January 1, 2015 to December 31, 2015

Round Two Model Test: January 1, 2015 to December 31, 2018 (Inclusive of a pre-implementation period of up to 12 months)

I. FUNDING OPPORTUNITY DESCRIPTION

1. Purpose

This notice provides requirements for the second round of funding for the State Innovation Models (SIM) program. SIM is based on the premise that state innovation with broad stakeholder input and engagement, including multi-payer models, will accelerate delivery system transformation to provide better care at lower costs. SIM is focused on public and private sector collaboration to transform the state's delivery system. SIM provides financial and technical support to states to test the ability of state governments to use their regulatory and policy levers to accelerate health transformation. In Round 1, CMS partnered with 6 Model Test states to implement state-wide health transformation strategies and 19 Model Design states to develop and refine State Healthcare Innovation Plans to guide future implementation efforts.

Drawing on lessons from the funding opportunity released in Round 1, *State Innovation Models: Funding for Model Design and Testing Assistance (CMS-1G1-12-001)* (Round 1 FOA), Round 2 of SIM specifies additional parameters that CMS believes correlate with successful state-wide health transformation. These parameters are described in this Funding Announcement in the form of requirements for Round 2 applications. CMS will fund up to 12 Model Test states with approximately \$20-100 million grants per state, with funding based in part on the size of the state population and the scope of the transformation proposal. Additionally, CMS will provide up to \$3 million per state for up to 15 Model Design cooperative agreements to design new State Health System Innovation Plans or enhance existing plans developed in Round 1. All Round 1 Model Design states must apply for Round 2 of SIM. The Round 1 FOA indicated that states receiving Round 1 Model Design awards must submit a Model Testing proposal for the Round 2 FOA. CMS is amending that requirement to submit a testing proposal in Round 2, so that a Model Design state may either apply for a Model Test award or may apply for a second Model Design award in order to enhance their State Health System Innovation Plan for future testing.

2. Authority

Section 1115A of the Social Security Act (the Act) authorizes the Center for Medicare and Medicaid Innovation (Innovation Center) to test innovative health care payment and service delivery models that have the potential to lower Medicare, Medicaid, and CHIP spending while maintaining or improving the quality of beneficiaries' care. The Act provides explicit authority for the Innovation Center to collaborate with states to test and evaluate all-payer payment reform for medical care of residents of the state. [Social Security Act, Section 1115A(b)(2)(B)(xi)]. The Innovation Center will use this authority to provide states funding for the design, testing, and evaluation of innovative payment

and service delivery models that integrate community resources with the state health system to drive broad health transformation.

3. Background

The purpose of the Innovation Center is to test innovative payment and service delivery models to reduce Medicare, Medicaid, and CHIP program expenditures while preserving or enhancing the quality of care received by CMS beneficiaries. The Innovation Center believes that state governments, with the leadership of Governors, can be critical partners of the federal government and other health care payers to facilitate the design, implementation, and evaluation of community-centered health systems that can deliver significantly improved cost, quality, and population health performance results for all state residents, including Medicare, Medicaid, and CHIP beneficiaries. States have policy and regulatory authorities, as well as ongoing relationships with private payers, health plans, and providers that can accelerate delivery system reform. Furthermore, with the implementation of health care reform through the Affordable Care Act, states are also positioned to influence the provision of health care to expanded populations of Medicaid residents as well as consumers purchasing health coverage under the Health Insurance Marketplaces.

This Funding Announcement expands on the State Innovation Models Round 1 Funding Announcement (CMS-1G1-12-001) by specifying additional parameters CMS believes correlate with successful state-wide transformation. As discussed in Section I.4, Proposal Requirements, funded proposals must articulate both a broad vision for state-wide health care transformation and describe ambitious, realizable programs in identified areas. States applying to SIM must commit to use a range of their regulatory, payment, and policy authorities to facilitate transformation. They must also demonstrate prior experience and future plans to convene varied private and public stakeholders to drive consensus in a manner that is likely to enhance and accelerate the development of innovative health system models and provide improved health and health care at reduced costs. Further, as a condition of the awards, the state must commit to sustain its model after the design and/or test period.

Among other factors, CMS will select and evaluate Model Test and Design proposals on the basis of their potential impact on the health of the entire state population.

4. Proposal Requirements

This Funding Announcement offers two separate funding opportunities: (1) Model Test awards and (2) Model Design awards.

A. Model Test: Proposal Requirements

The Innovation Center will award up to 12 Model Test awards to states through this Funding Announcement. Model Test awards will provide financial and technical support to implement fully developed proposals for successful state-wide transformation. Awards will range from \$20-100 million per state totaling \$700 million over a four-year period, based on the size of the state's population and the scope of the proposal. If a Model Test applicant is not selected for a Model Test award, CMS may select the state/entity for a Model Design award if (1) after all possible states/entities which applied for Model Design awards are selected and funding is still available to issue additional Model Design awards (not to exceed overall maximum of 15 Model Design awards); and (2) CMS determines the state/entity is not ready for a Model Test award and would benefit from Model Design funding. **States currently engaged in a Model Test award with CMS will not be eligible to apply for funding in Round 2.**

The selection criteria for the Round 2 Model Test application will be based on a state's ability to successfully apply policy and regulatory levers over the award performance period to address three focus areas: (1) improving population health; (2) transforming health care delivery systems; and (3) decreasing per capita total health care spending. During the selection process, CMS will require additional discussions with applicants regarding their proposals. Selection for a Round 2 Model Test will not constitute nor guarantee approval of a request for a Medicaid State Plan Amendment (SPA) or a Medicaid 1115 Waiver. States seeking a Medicaid SPA or Medicaid 1115 waiver may do so under established processes.

In addition to an expert panel review, selected applicants for Model Test cooperative agreements will be required to present their Round 2 proposals. Selected applicants will be invited and strongly encouraged to present their proposal in person, or conversely can present virtually to a panel comprised of external experts as well as HHS leadership. The state's presentation must be led by a cabinet-level health official, such as the Secretary of Health, and include providers and commercial payers who have committed to actively participate in the model. In the case of public-private partnership entities applying for a state innovation model test, senior leaders from the private and public sector, including senior leaders of the applicant entity, shall be present. All travel expenses incurred by applicants will not be reimbursed by CMS nor can they be reimbursed by any funding awarded under this FOA. In addition, if a state does not participate in the required presentation, it will not be eligible for funding.

Model Test applications must address the following required areas:

- i. **Model Test Project Narrative.** The state must produce a detailed and fully developed proposal capable of creating state-wide health transformation for the

preponderance of care within the state. For each individual element and/or program in the test proposal, the state must highlight how the element or program will (1) improve population health; (2) transform the health care delivery system; and/or (3) decrease per capita health care spending, drawing on a supporting evidence base.

While Round 2 provides states with significant flexibility to design contextually-specific plans for state-wide health transformation, each proposal must also include the following core elements:

(1) *Plan for improving Population Health.* The state must develop a state-wide plan to improve population health during the project period. The state will be offered the opportunity to obtain technical support from the Centers for Disease Control in developing the plans. The plans should include integration of population health strategies with public health officials and health care delivery systems for all populations. At a minimum, plans should address the core measures identified in the population health metrics document, namely: tobacco use and the incidence of obesity, and diabetes. (See Appendix 1.) In addition, states should consider integrating state strategies to address child wellness and prevention priorities, as applicable, including such factors as reducing childhood obesity, preventing early childhood dental caries, and addressing maternal depression to foster healthy child development.

(2) *Health Care Delivery System Transformation Plan.* CMS has identified the following characteristics to be closely associated with transformed health care delivery systems:

- a. Providers across the state and across the care continuum participate in integrated or virtually integrated delivery models;
- b. Over 80% of payments to providers from all payers are in fee-for-service alternatives that link payment to value;
- c. Every resident of the state has a primary care provider who is accountable both for the quality and for the total cost of their health care;
- d. Care is coordinated across all providers and settings;
- e. There is a high-level of patient engagement and quantifiable results on patient experience;
- f. Providers leverage the use of health information technology to improve quality;
- g. There is an adequate health care workforce to meet state residents' needs;

- h. Providers perform at the top of their license and board certification;
- i. Performance in quality and cost measures is consistently high;
- j. Population health measures are integrated into the delivery system; and
- k. Data is used to drive health system processes.

The state must describe in detail how it will engage providers in health care delivery system transformation across the state, working towards the goals described above.

CMS recognizes that individual state proposals will vary considerably. However, in reviewing the Health Care Delivery Transformation Plan, and the proposed cost and quality targets, CMS will consider state, regional, and national demographics, proposal parameters, alignment/overlap of existing CMS programs, and other factors that impact health.

- (3) *Payment and/or Service Delivery Model*: One or more specific payment and/or service delivery models that include, but are not limited to, the state's Medicaid population, state employee population, and/or commercial payers' populations. The payment and/or service delivery models must identify the targeted populations, the number of beneficiaries served, the number of participating providers, and the services to be delivered. **CMS encourages applicants to propose payment models that directly align with one or more existing Medicare programs, demonstrations, and/or models, such as accountable care organizations (ACOs), primary care medical homes, and bundled payment programs.** Medicare's participation is not guaranteed and will be assessed on a case-by-case basis after thorough review of the proposed model.

As SIM aims to reach a preponderance of a state's population and Medicaid can serve as an important lever for driving health care delivery system transformation, the state should describe any Medicaid expansion activities and the percentage of the state's population that is covered by Medicaid.

- (4) *Leveraging Regulatory Authority*. The state must commit to using multiple regulatory authorities to influence the structure and performance of the state's health care system. Regulatory authorities whose uses are envisioned under SIM include, but are not limited to, the following:

- a. Aligning certificate of need processes and criteria (if applicable) to reinforce accountable care and delivery system transformation or developing alternative approaches to certificate of need programs, such as community-based approaches that could include voluntary participation by all providers and payers;
- b. Developing regulatory approaches to improve the effectiveness, efficiency and appropriate mix of the health care work force, such as through professional licensure/accreditation of providers and/or expanding scope of practice statutes;
- c. Creating opportunities to align state regulations and requirements for health insurers with the broader goals of multi-payer delivery system and payment reform;
- d. Integrating value-based principles into health insurance exchange Qualified Health Plan (QHP) certification processes, state employee plans, or Medicaid managed care plans including through selective contracting with carriers to provide health care coverage plans that provide the most competitive combination of value, quality, and choice; and
- e. Requiring academic medical centers and professional schools to integrate transformation-based teachings into medical education programs.

This list is not intended to be exhaustive. States may propose alternative regulatory authorities that support delivery system transformation to satisfy this requirement in consultation with CMS.

- (5) *Health Information Technology*. CMS recognizes that health information technology and data analytics will be important to achieving optimal efficiency and improved outcomes in state-wide health care delivery. States may propose to use SIM funds for the implementation of specific technology, software, applications, or other analytical tools as part of state infrastructure development to support the Model Test as long as the state provides a clear strategy for how, if applicable, the technological approach will be financed in addition to SIM, how it will not supplant other funding sources, and how it will be sustained after the cooperative agreement period has ended. Proposals must document the current state of health information technology adoption and utilization in the state, including current EHR adoption levels, percentage of providers meeting Meaningful Use requirements in the EHR Incentive Programs, and use of technology to support HIE activities. The Model Test proposals must also provide detailed descriptions for health information technology plans in the following domains:

- a. *Governance*: Describe how state leadership will direct the planning and oversight of implementation; supply a comprehensive plan to implement infrastructure to support the Model Test that leverages existing assets and aligns with federally-funded programs and state enterprise IT systems; and explain how the governance structure will incorporate and expand existing public/private health information exchanges, including those operated by ACOs.
- b. *Policy*: Describe policy and regulatory levers that will be used to accelerate standards based health information technology adoption to improve care in the state Model Test; describe methods to improve transparency and encourage innovative uses of data; offer a plan for promotion of patient engagement and shared-decision making; and propose multi-payer strategies to enable and expand the use of health information technology.
- c. *Infrastructure*: Describe how the state will implement analytical tools and use data driven evidence based approach to coordinate and improve care across the state Model Test; offer plans to utilize telehealth and perform remote patient monitoring to increase access to care and the timeliness of care; articulate plans to use standards based health IT to enable electronic quality reporting; explain how public health IT systems (such as clinical registry systems) will be integrated; and describe how support of electronic data will drive quality improvement at the point of care.
- d. *Technical Assistance*: Define how the state will provide technical assistance to providers; identify targeted provider groups that will receive assistance and what services will be delivered; and identify how the state intends to extend resources to providers ineligible for Meaningful Use incentive payments, if applicable.

This list is not intended to be exhaustive. States may propose alternative approaches to data analytics and health information technology that support delivery system transformation. States will be offered the opportunity to obtain technical support from the Office of the National Coordinator for Health IT in developing the plans.

In addition to explaining the individual components of the test, the State must address its rationale for how the specified elements and/or programs, in combination, will achieve state-wide health transformation.

States may elect to focus on select areas of the state and/or to sequence elements or programs in the test geographically or temporally. The state should identify the test's geographic scope in this section and address any sequencing of individual elements and/or programs in its response to "Section I.4.A.iv., Operational Plan," below.

- (6) *Stakeholder Engagement.* The state must demonstrate how it will use its unique role as a stakeholder convener to accelerate state-wide health transformation. The state must (1) demonstrate that there are a significant number of key stakeholders representative of the entire state population engaged and actively committed to the implementation of the state's Model Test proposal and (2) present a clear and pragmatic strategy for maintaining stakeholder commitment throughout implementation of the proposed test. Stakeholders must include health care providers/systems, commercial payers/purchasers, state hospital and medical associations, community-based and long term support providers, consumer advocacy organizations, and, as applicable, tribal communities.

The state must submit attestations of support from each identified stakeholder as part of its application (template provided in Appendix 3). Notwithstanding the above, representatives from stakeholder organizations must be prepared to travel to CMS or participate in a virtual teleconference during the selection process to discuss their commitment to the state's proposal.

- (7) *Quality Measure Alignment.* The state must provide plans to develop a state-wide plan to align quality measures across all payers in the state. If the state and key stakeholders have not yet reached consensus on such a plan at the time of submission, the proposal must describe in detail any progress to date on quality measure alignment, including the successes and challenges faced, and must articulate a path for developing a realizable plan by the conclusion of the up to 12 month pre-implementation period. The plan should also demonstrate the payers' commitment to reducing the administrative and/or non-clinical burden to providers in the state.

- (8) *Monitoring and Evaluation Plan.* The state must provide quantifiable measures for regularly monitoring the impact of its proposed model, including the effectiveness of the policy and regulatory levers applied under the Model Test, on the three key outcomes of (1) strengthening population health; (2) transforming the health care delivery system; and (3) decreasing per capita health care spending. Measures should be selected with a focus on the particularized state health demographics and health needs the Model Test

proposal aims to address. All quality and cost measures must use the state's entire population in the denominator. Examples of measure domains that may apply include:

- Population health: percentage of state residents using tobacco
- Health care delivery system transformation: percentage of state residents attributed to a primary care doctor
- Per capita cost spending: per capita Medicare inpatient costs

Final measures will be refined in conjunction with CMS during the up to 12 month pre-implementation period.

The state also will be responsible for monitoring and reporting to CMS on the progress and impact of its Model Test at regular intervals. In addition, CMS will conduct an independent evaluation of funded proposals in accordance with the requirements set forth in Section 1115A of the Social Security Act (added by Section 3021 of the Affordable Care Act).

- (9) *Alignment with State and Federal Innovation.* The state must identify all existing health care innovation initiatives occurring within the state, including CMS, HHS, federal, and external initiatives (*e.g.*, the Robert Wood Johnson Foundation Aligning Forces for Quality program), and demonstrate how the proposal aligns with these health care innovation efforts. The state must describe how the proposal will (1) coordinate with and build upon existing initiatives and (2) ensure that federal funding will not be used for duplicative activities, or to supplant current federal or state funding. For example, if a state is participating in the State Financial Alignment Model, the state should describe how the State Financial Alignment Model complements the state's proposed SIM model.
- ii. **Budget Narrative.** As part of its application, the state must submit a SF-424A and a budget narrative. The budget narrative must be consistent with the SF-424A and Model Test requirements as well as limit overhead and administrative costs to no more than 10% of direct costs. States should indicate other resources that will aid in implementing the Model Test plan. See Section IV. 2. *Content and Form of Application Submission* for more information.
- iii. **Financial Analysis.** As part of its application, the state must submit a Financial Analysis. The Financial Analysis must estimate the proposal's return on investment for the Model, and specifically for Medicare, Medicaid, and/or CHIP populations, over the performance period of the award as well as on a projected

annualized basis after the term of the award is finished. The state must explain how its interventions will reduce total cost of care for the beneficiaries its model serves. The Financial Analysis also must provide financial models explaining the logic driving their forecasted cost of care savings.

The state must obtain and submit an external actuarial certification of their Financial Analysis with their application. A qualified actuary who is a member of the American Academy of Actuaries must complete the external certification. The CMS Office of the Actuary will assist in reviewing the reasonableness of the estimated cost to the government, and will review the potential for federal savings. The external actuarial certification, as well as the review of the CMS Actuary, will be considered in final selection of Model Test awards.

- iv. **Operational Plan.** The state must submit a detailed Operational Plan that describes the activities and budgets for each year of the model and provide a detailed timeline for implementation and major milestones for successfully executing the Plan. The Operational Plan must show how the applicant plans to scale implementation activities to ramp up to an operational start within twelve months of receiving funding. The applicant must also establish accountability targets for the project, including specific quarterly milestones and metrics associated with each investment or activity that would be financed in whole or in part by this award. Projected quarterly targets for the test period should indicate the number and/or proportion of health care providers, hospitals, and beneficiaries that will be engaged by each Model Test component. The Operational Plan must also address any assumptions made and risks to the operational timeline, probability and impact of identified risks actually occurring, and projected strategies for mitigating identified risks.

In addition, the application should show that the applicant has the resources and track record needed to operate the model and report on the progress it is making during the operation. Applicants shall include a list of key personnel; and for each person on this list, applicants should describe their relevant background, their roles, and overall responsibility. Applicants should address the Governor's existing and future involvement in the model's design and implementation, and the state agencies and/or departments that will be actively involved in executing the model.

Applicants may also propose an operational plan that implements their State Health System Innovation Plan through a public-private partnership. Under such an approach, the state must demonstrate active engagement and participation in the public-private partnership.

B. Model Design: Proposal Requirements

The Innovation Center will award up to 15 Model Design states through this Funding Announcement. Model Design awards will provide financial and technical support to design proposals for successful state-wide transformation. Awards will range from \$1-3 million over a one-year project period.

Eligible states include both those that did not participate in Round 1, as well as Round 1 Model Design states that met the terms and condition of the Round 1 project but require additional design work in order to implement the plan (i.e. increased stakeholder engagement, measurable public health value, cost and quality targets). Round 1 Model Design state proposals shall include the extent to which the state will develop a design that enhances the existing state plan for delivery transformation. To the extent feasible, Round 2 Model Design awardees will be required to implement and test the plans they develop.

Model Design applications must address the following required areas:

- i. **Model Design Project Narrative.** The state must demonstrate a clear process for designing or refining a plan with the engagement of multiple components of state government. The state should address the elements detailed in Section I.4.A.i, Model Test Project Narrative, and listed by name below, including specifically identifying the levers the state will aim to incorporate into a comprehensive state plan, such as the state's Medicaid program, state employee health plans, and stated-owned academic medical centers. In their design plans, states must explain the unique features of their design efforts and their strategies for designing a plan that aligns with existing CMS efforts. Further, state plans must include multiple payers. This narrative must include a modified stakeholder engagement strategy, as outlined in Section I.4.B.i.6, below.
 - (1) *Plan for Improving Population Health*
 - (2) *Health Care Delivery System Transformation Plan*
 - (3) *Payment and/or Service Delivery Model*
 - (4) *Leveraging Regulatory Authority*
 - (5) *Health Information Technology*
 - (6) *Stakeholder Engagement.* The application must identify the proposed stakeholders that will actively participate in the Model Design process and present a clear and pragmatic strategy for engaging and maintaining their commitment to developing a State Health System Innovation Plan. States are

expected to work with a broad group of stakeholders representative of the entire state population in their Model Design process, including, but not limited to, a significant number of health care providers/systems, long term service and supports providers, commercial payers, state hospital and medical associations, tribal communities and consumer advocacy organizations. The state must describe the strategy for designing a state health plan that includes multi-payer payment innovation and measure alignment.

(7) *Quality Measure Alignment*

(8) *Monitoring and Evaluation Plan*

(9) *Alignment with State and Federal Innovation*

- ii. **Budget Narrative.** As part of its application, the state must submit a SF-424A and a budget narrative. The budget narrative must be consistent with the SF-424A and Model Design requirements as well as limit overhead and administrative costs to no more than 10% of direct costs. States should indicate other resources that will aid in designing the State Health System Innovation Plan. See Section IV. 2. *Content and Form of Application Submission* for more information.
- iii. **Financial Analysis.** As part of its application, the state must submit a Financial Analysis. The Financial Analysis must, at minimum, describe the populations being addressed and their respective total medical and other services costs as per member per month and population total. If known, the Financial Analysis should also describe (1) anticipated cost savings resulting from specified interventions, including the types of costs that will be affected by the model and the anticipated level of improvement by target population and (2) expected total cost savings and return on investment for the overall state model and basis for expected savings (previous studies, experience, etc.).
- iv. **Operational Plan.** The state must submit a detailed Operational Plan that describes the activities and budgets for the performance period of the award and a detailed timeline for the design process with major milestones. The plan should also include roles and responsibilities of key partners and payer participants (if applicable) and major milestones and dates for successfully executing the Operational Plan. Applicants also should include a list of key personnel; for each person on this list, applicants should describe their relevant background, their roles, and overall responsibility. Applicants should address the Governor's existing and future involvement in the model's design and implementation, and the state agencies and/or departments that will be actively involved in designing the model.

Applicants may also propose an operational plan that seeks to design the State Health System Innovation Plan through a public-private partnership. Under such an approach, the state must demonstrate active engagement and participation in the public-private partnership.

The operational plan must also address any assumptions made and risks to the operational timeline, and projected strategies for mitigating identified risks.

5. Limitations on Design

The following are areas that are out of scope and will not be considered under the state Innovation Models initiative:

- a. Medicare eligibility changes;
- b. Coverage or benefits reductions in Medicare or Medicaid or any changes that would have the effect of rationing care;
- c. Increases in premiums or cost sharing;
- d. Increases in net federal spending under the Medicare, Medicaid or CHIP programs;
- e. Medicaid FMAP formula changes;
- f. Changes to the EHR incentive program for eligible professionals and eligible hospitals;
- g. Changes in State Financial Alignment Models;
- h. Reductions in Medicare beneficiary choice of provider or health plan, or Medicaid choice of provider or health plan beyond those allowed today, or changes to maintenance of effort requirements;
- i. Changes to CMS sanctions, penalties, or official denial of participation currently in effect.

6. Funding Restrictions

CMS will not fund proposals that duplicate models for populations that are already being funded and tested as part of any other CMS and/or HHS initiatives. For example, if the state receives a Strong Start for Mothers and Newborns cooperative agreement, SIM funding will only be used in a coordinated manner to complement and not to duplicate or supplant funding for Strong Start for Mothers and Newborns. SIM funding may not supplant existing federal or state funding. States may propose the use of SIM test funds to

support additional costs associated with or created by testing a SIM model. States may not use SIM funds as state match under the Medicaid or CHIP programs nor use funds to substitute for currently funded Medicaid or CHIP services or administrative activities.

7. Requests for Data

CMS is willing to accept requests from the state or its agents for data necessary for the development and/or implementation of Model Test and Model Design proposals. Such data could include de-identified (by patient or by provider) or even individually identifiable health information such as claims level data. All such requests for individually-identifiable health information must clearly state the HIPAA basis for requested disclosure. CMS will review such requests to determine if it is possible to meet awardees' data requests. Appropriate privacy and security protections will be required for any data disclosed under this Model.

8. Anticipated Substantial Involvement by CMS

CMS requires substantial involvement in the Round Two Model Test and Model Design cooperative agreements. CMS reserves the right to require amendment of the state's Model Design or Model Test proposals following award selection, including for the purposes of integrating new best practices around successful health transformation.

Continued disbursement of SIM funding over the performance period of the award is conditional on the state meeting specified Model Test and Model Design progress benchmarks. These benchmarks will be outlined in the terms and conditions of the cooperative agreement.

9. Waivers for Models Conducted under SSA Section 1115A

The authority for State Innovation Models is section 1115A of the Social Security Act (SSA). Under section 1115A(d)(1) of the SSA, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII (including certain fraud and abuse provisions) and of sections 1902(a)(1), 1902(a)(13) and 1903(m)(2)(A)(iii) of the Act as may be necessary solely for purposes of carrying out section 1115A with respect to testing models described in section 1115A(b). No waivers are issued in this document or guaranteed for this model. Notwithstanding any other provision of this document, state initiatives must comply with all applicable federal laws and regulations, except as explicitly provided in separately documented waivers, if any, issued pursuant to section 1115A(d)(1) specifically for the State Innovation Models Initiative. Any such waiver would apply solely to State Innovation Models Initiative and could differ in scope or design from waivers granted for other programs or models.

II. AWARD INFORMATION

1. Total Funding

CMS will award up to \$30 million for up to 15 states for Model Design cooperative agreements and up to \$700 million in funding for up to 12 state-sponsored Model Test cooperative agreements through this Round 2 Funding Announcement.

All states, the District of Columbia, and U.S. Territories may submit applications for Model Test and Model Design funding in Round 2 through this FOA except that States currently engaged in a Model Test with CMS are ineligible to apply for a Round 2 award. States that received Model Design awards through Round 1 SIM funding (*State Innovation Models: Funding for Model Design and Testing Assistance, CMS-1G1-12-001*) must apply for either a Model Test award or for a second Model Design award. States that did not participate in Round 1 may apply for either a Model Design or Model Test award, but not both. If a Model Test applicant is not selected for a Model Test award, CMS may select the state/entity for a Model Design award if (1) after all possible states/entities which applied for Model Design awards are selected and funding is still available to issue additional Model Design awards (not to exceed overall maximum of 15 Model Design awards); and (2) CMS determines the state/entity is not ready for a Model Test award and would benefit from Model Design funding.

2. Award Amount

Model Test: Up to 12 Model Test cooperative agreements will be awarded under this State Innovation Models initiative. Awards for Model Test states will range from \$20-100 million per state, based on the size of the state population and the scope of the proposal. During the selection process, each state's budget plan will be reviewed to determine appropriateness of the amount requested based on the model's complexity, size of the target population, spectrum of state policy activity, level of multi-payer and other stakeholder engagement, the return on investment, and the strength of the evidence base or logic model in supporting the expected impact of the Plan. The proposal's savings estimates will be reviewed for their reasonableness by the CMS Office of the Actuary.

The amount awarded will include any state cost of testing the model and meeting state and federal evaluation requirements as specified in Section V.3 below. While the Innovation Center is responsible for the evaluation of each Model Test, states must also develop their own model evaluation process, under the guidance of the Innovation Center. The state evaluations should include an examination of the model's impact on the entire state population. In general, CMS expects that Model Test awards will cover only costs that are not normally part of a state's operational cost, data collection cost, or administrative cost.

Model Design: State Model Design awards will be based on the budget submitted by the state to support its work to produce or refine a State Health System Innovation Plan and Model Design proposal. The range for Model Design cooperative agreement awards is \$1 million to \$3 million. Consideration will be given to the size of the Medicaid, CHIP, and Medicare population in the state as well as the overall scope and sustainability of the proposal.

For both Model Test and Model Design awards, state budget proposals will be reviewed to determine the appropriateness of itemized budget expenditure estimates and the total requested amount. CMS reserves the right to request modifications to the budget and expenditure plan.

3. Anticipated Award Date

CMS expects to announce which states are being awarded cooperative agreements for Model Test and Model Design awards on or around October 31, 2014.

4. Period of Performance

Initial funding of Model Test and Model Design awards is contingent upon the state's acceptance of the award's terms and conditions through the initial drawdown of funds and, in the case of Model Test awards, explicit CMS approval of an operational plan submitted by the state.

States receiving Model Design awards have twelve months from the award start date to complete their State Health System Innovation Plans and Model Designs. The project period and budget period for Model Design will be one year, anticipated to be until December 31, 2015.

The 48-month project period for Model Test will be divided into four budget periods, with an initial budget period of twelve months for pre-implementation work followed by three budget periods of 12 months each. Following the initial twelve-month budget period, non-competing continuation awards will be granted for each additional year of the cooperative agreement contingent upon availability of funding, state performance, and demonstrated progress towards the goals and objectives of this FOA. The anticipated test completion date for states receiving Model Test awards is December 31, 2018. The specific period of performance for each state model will be included in the cooperative agreement and be executed upon the initial drawdown of funds by the recipient.

5. Number of Awards

Round two will award up to 15 states with Model Design cooperative agreements and up to 12 states with Model Test cooperative agreements.

6. Type of Award

Awards are for cooperative agreements.

7. Termination of Award

Continued funding is dependent on satisfactory performance against goals and performance expectations delineated in the cooperative agreement's terms and conditions and, if applicable, approved operational plans. CMS reserves the right to terminate the cooperative agreement if it is determined to be in the best interests of CMS. Projects will be funded subject to meeting terms and conditions of the award, and subject to Section 1115A(b)(3)(B) of the Social Security Act, which requires the Secretary to terminate or modify the design and implementation of a model unless it is determined after testing has begun that it is expected to improve quality of care without increasing Medicare, Medicaid and CHIP spending; reduce Medicare, Medicaid and CHIP spending without reducing quality of care; or improve quality of care and reduce spending for Medicare, Medicaid, and CHIP beneficiaries.

CMS also may terminate or modify a cooperative agreement based upon CMS review of the state's progress, including a review of whether or how well quality and savings targets are met. In such cases CMS staff will make a recommendation to the CMS Administrator based on the best interests of CMS including consideration of the Innovation Center's mission to test and evaluate new payment and service delivery models.

III. ELIGIBILITY INFORMATION

1. Eligible Applicants

CMS invites the 50 state Governor's Offices, United States Territories Governors' Offices (American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the Virgin islands), and the Mayor's Office of the District of Columbia to apply.

- Only one application from a Governor per state is permitted for either a Model Design or a Model Test award (assuming the state applied and was not selected for funding under the first round of Model Test awards).
- A state cannot receive multiple Round 2 Model Design or Model Test awards.
- A state cannot receive both a Round 2 Model Design award and a Round 2 Model Test award.

- Each application must include a letter from the Governor (or the Mayor, if from the District of Columbia) officially endorsing the application for a Model Design award or for a Model Test award.
- States currently engaged in a Model Test award with CMS are NOT eligible to apply for funding under Round 2.

A state may propose that an outside organization focused on quality and state delivery system transformation, such as a non-profit affiliated with the State Department of Health or a public-private partnership supported by the Governor's Office, receive and administer funds through a Model Design or Model Test award. The Governor's Office must submit such requests in writing to CMS with its Letter of Intent and include a justification for the request and an attestation that the state will actively participate in all activities described in its proposal. Approval of such requests will be at the sole discretion of CMS. Only one such request supported by the Governor will be allowed per state. A state pursuing this approach will still be expected to address all of the required areas described in this FOA.

Eligibility Threshold Criteria:

- All applicants must have submitted a required letter of intent to the programmatic point of contact in Section VI, *Agency Contacts* by June 6, 2014. If a letter of intent has not been submitted by the required due date, any subsequent application submitted by the entity will be ineligible. See Section IV.2.A, *Letter of Intent to Apply*, for more information.
- Application deadline: Applications not received by the application deadline (TBD) through www.grants.gov will not be reviewed.
- Application requirements: Applications will be considered for funding only if the application meets the requirements outlined in Section III, Eligibility Information and Section IV, Application and Submission Information.
- Page limits: Model Test applications shall not be more than 55 pages in length. Model Design applications shall not be more than 27 pages in length. Both types of applications must be limited to the page maximums, sequence of sections, and section content specified in Section IV.2 Content and Form of Application Submission, parts C & D.
 - In addition, applications should include attestations of support from key stakeholders. The letters of support will not be included in the page limits for applications. The letters should attest to stakeholders' active engagement in the model and must contain specific information about how the stakeholders will contribute to the SIM process.

- The standard forms, project abstract, Governor’s endorsement, and curriculum vitae are also not included in these page limits.

States are strongly encouraged to review the criteria information provided in Section V, Application Review Information, to help ensure that the proposal adequately addresses all the criteria that will be used in evaluating applications and determining appropriate funding levels for each award.

Employer Identification Number: All applicants must have a valid Employer Identification Number (EIN) assigned by the Internal Revenue Service.

Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS number): All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number in order to apply. The DUNS number is a nine-digit identification number that uniquely identifies business entities. Obtaining a DUNS number is free. To obtain a DUNS number, access the following website: www.dunandbradstreet.com or call 1-866-705-5711. See Section IV, Application and Submission Information, for more information on obtaining a DUNS number.

System for Award Management (SAM): All applicants must register in the System for Award Management (SAM) database (formerly CCR) (<https://www.sam.gov/portal/public/SAM>) in order to be able to submit an application at <http://www.grants.gov>. The SAM process is a separate process from submitting an application. **Applicants should begin the SAM registration process as soon as possible after the announcement is posted to ensure that it does not impair your ability to meet required submission deadlines.** In order to register, applicants must provide their DUNS and EIN numbers. Additional information about SAM is available at <https://www.sam.gov/portal/public/SAM/>.

Applicants must successfully register with SAM prior to submitting an application or registering in the Federal Funding Accountability and Transparency Act Subaward Reporting System (FSRS) as a prime awardee user. Organizations must report executive compensation as part of the registration profile at <https://www.sam.gov/portal/public/SAM> by the end of the month following the month in which this award is made, and annually thereafter (based on the reporting requirements of the Federal Funding Accountability and Transparency Act (FFATA) of 2006 (Pub. L. 109-282), as amended by Section 6202 of Public Law 110-252 and implemented by 2 CFR Part 170)). Primary awardees must maintain a current registration with the SAM database, and **may make subawards only to entities that have DUNS numbers.** See Section VI, *Award Administration Information*, for more information on FFATA.

The Grants Management Specialist assigned to monitor the subaward and executive compensation reporting requirements is Iris Grady, who can be reached at divisionofgrantsmanagement@cms.hhs.gov.

2. Cost Sharing or Matching Requirements

Cost sharing or matching is not required.

3. Foreign and International Organizations

Foreign and international organizations are not eligible to apply.

4. Faith-Based Organizations

Faith-based organizations are not eligible to apply.

IV. APPLICATION AND SUBMISSION INFORMATION

1. Address to Request Application Materials

This Funding Opportunity Announcement serves as the application package for this cooperative agreement and contains all the instructions to enable a potential applicant to apply. The application should be written primarily as a narrative with the standard forms required by the Federal government for all cooperative agreements. A separate and complete application must be submitted for each type of submission and for each round of submission.

2. Content and Form of Application Submission

A. Letter of Intent to Apply

A non-binding letter of intent to apply must be submitted to the CMS programmatic contact listed in Section VI. *Agency Contacts* by June 6, 2014. Entities which do not submit a letter of intent by this deadline will be ineligible to apply. As explained in Section III. Eligibility Information, a Governor must submit an official request, along with its letter of intent, if it plans to propose that an outside organization focused on quality and state delivery transformation, such as a non-profit affiliated with the State Department of Health or a public-private partnership supported by the Governor's Office, receives and administers funds through a Model Design or Model Test award. A justification must be included with the request as well as an attestation that the state will actively participate in all activities described in the proposal. Approval of such requests will be at the sole discretion of CMS. Only one application supported by the Governor will be allowed per state.

B. Application Materials

Application materials will be available for download at <http://www.grants.gov>. Please note that HHS requires applications for all announcements to be submitted electronically through <http://www.grants.gov>. For assistance with Grants.gov, contact support@grants.gov or call 1-800-518-4726. The Funding Opportunity Announcement can also be viewed on the Innovation Center website at <http://innovations.cms.gov>. Specific instructions for applications submitted via <http://www.grants.gov>:

- You can access the electronic application for this project at <http://www.grants.gov>. You must search the downloadable application page by the CFDA number shown on the cover page of this announcement.
- At the <http://www.grants.gov> website, you will find information about submitting an application electronically through the site, including the hours of operation. HHS strongly recommends that you do not wait until the application due date to begin the application process through <http://www.grants.gov>, because of the time needed to complete the required registration steps.
- All applicants under this announcement must have an Employer Identification Number (EIN) to apply. **Please note, the time needed to complete the EIN registration process can be substantial, and applicants should therefore begin the process of obtaining an EIN immediately upon posting of this FOA to ensure the EIN is received in advance of application deadlines.**
- All applicants, as well as sub-recipients, must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number at the time of application in order to be considered for a grant or cooperative agreement. A DUNS number is required for using the Government-wide electronic portal, www.grants.gov. The DUNS number is a nine-digit identification number that uniquely identifies business entities. To obtain a DUNS number, access the following website: www.dunandbradstreet.com or call 1-866-705-5711. This number should be entered in the block with the applicant's name and address on the cover page of the application (Item 8c on the Form SF 424, Application for Federal Assistance). The name and address in the application should be exactly as given for the DUNS number. **Applicants should obtain this DUNS number as soon as possible after the announcement is posted to ensure all registration steps are completed in time.**
- Authorized Organizational Representative: The Authorized Organizational Representative (AOR) who will officially submit an application on behalf of the organization must register with Grants.gov for a username and password. AORs must complete a profile with Grants.gov using their organization's DUNS Number to obtain their username and password, at

http://grants.gov/applicants/get_registered.jsp. AORs must wait one business day after registration in SAM before entering their profiles in Grants.gov. **Applicants should complete this process as soon as possible after successful registration in SAM to ensure this step is completed in time to apply before application deadlines.**

- When an AOR registers with Grants.gov to submit applications on behalf of an organization, that organization's E-Biz point-of-contact will receive an e-mail notification. The e-mail address provided in the profile will be the e-mail used to send the notification from Grants.gov to the E-Biz POC with the AOR copied on the correspondence.
- The E-Biz POC must then login to Grants.gov (using the organization's DUNS number for the username and the special password called "M-PIN") and approve the AOR, thereby providing permission to submit applications.
- **Any files uploaded or attached to the Grants.Gov application must be PDF file format and must contain a valid file format extension in the filename. Even though Grants.gov allows applicants to attach any file format as part of their application, CMS restricts this practice and only accepts PDF file formats. Any file submitted as part of the Grants.gov application that is not in a PDF file format, or contains password protection, will not be accepted for processing and will be excluded from the application during the review process. In addition, the use of compressed file formats such as ZIP, RAR, or Adobe Portfolio will not be accepted. The application must be submitted in a file format that can easily be copied and read by reviewers. It is recommended that scanned copies not be submitted through Grants.gov unless the applicant confirms the clarity of the documents. Pages cannot be reduced in size, resulting in multiple pages on a single sheet, to avoid exceeding the page limitation. All documents that do not conform to the above constraints will be excluded from the application materials during the review process.**
- After you electronically submit your application, you will receive an automatic email from <http://www.grants.gov> that contains a Grants.gov tracking number. **Please be aware that this notice does not guarantee that the application will be accepted by Grants.gov. Rather, this email is only an acknowledgement of receipt of the application by Grants.gov.** All applications must be validated by Grants.gov before they will be accepted. Please note, applicants may incur a time delay before they receive acknowledgement that the application has been validated and accepted by the Grants.gov system. In some cases, the validation process could take up to 48 hours. If for some reason the application is not accepted, then the applicant will receive a subsequent notice

from Grants.gov indicating that the application submission has been rejected. **Applicants should not wait until the application deadline to apply because notification by Grants.gov that the application is incomplete may not be received until close to or after the application deadline, eliminating the opportunity to correct errors and resubmit the application. Applications submitted after the deadline because the original submission failed validation and is therefore rejected by Grants.gov, as a result of errors on the part of the applicant, will not be accepted by CMS and/or granted a waiver.** For this reason, CMS recommends that applicants apply in advance of the application due date and time.

- After HHS retrieves your application package from Grants.gov, a return receipt will be e-mailed to the applicant contact. This will be in addition to the validation number provided by <http://www.grants.gov>.
- Each year organizations and entities registered to apply for Federal grants and cooperative agreements through <http://www.grants.gov> will need to renew their registration with the System for Award Management (SAM). You can register with SAM online; registration will take about 30 minutes to complete (<https://www.sam.gov/portal/public/SAM/>). **Failure to renew SAM registration prior to application submission will prevent an applicant from successfully applying via Grants.gov. Similarly, failure to maintain an active SAM registration during the application review process can prevent HHS from issuing your agency an award under this program.**

Applications cannot be accepted through any email address. Full applications can only be accepted through <http://www.grants.gov>. Full applications cannot be received via paper mail, courier, or delivery service.

All applications for the awards must be submitted electronically and be received through <http://www.grants.gov> by the deadlines listed below:

All applications will receive an automatic time stamp upon submission and state applicants will receive an e-mail reply acknowledging the application's receipt.

Please be aware of the following:

- 1) Search for the application package in Grants.gov by entering the CFDA number. This number is shown on the cover page of this announcement.
- 2) If you experience technical challenges while submitting your application electronically, please contact Grants.gov Support directly at: www.grants.gov/customer-support or (800) 518-4726. Customer Support is

available to address questions 24 hours a day, 7 days a week (except on Federal holidays).

- 3) Upon contacting Grants.gov, obtain a tracking number as proof of contact. The tracking number is helpful if there are technical issues that cannot be resolved.

To be considered timely, applications must be received by the published deadline date. However, a general extension of a published application deadline that affects all state applicants or only those in a defined geographical area may be authorized by circumstances that affect the public at large, such as natural disasters (e.g., floods or hurricanes) or disruptions of electronic (e.g., application receipt services) or other services, such as a prolonged blackout.

Grants.gov complies with Section 508 of the Rehabilitation Act of 1973. If an individual uses assistive technology and is unable to access any material on the site, including forms contained with an application package, he or she can e-mail the Grants.gov contact center at support@grants.gov for help, or call 1-800-518-4726.

C. Format Requirements for Applications

Each application must include all contents described below, in the order indicated, and in conformance with the following specifications:

- Use 8.5” x 11” letter-size pages with 1” margins (top, bottom, and sides). Other paper sizes will not be accepted. This is particularly important because it is often not possible to reproduce copies in a size other than 8.5” x 11”.
- All pages of the project narrative must be paginated in a single sequence.
- Font size must be 12-point with an average character density no greater than 14 characters per inch.
- The budget and project narrative portions of the application must be double-spaced.
- The project abstract is restricted to a one-page summary, which can be single-spaced.

Applications and attached proposals must not be more than 55 pages in length for Model Test awards, and no more than 27 pages for Model Design awards. For Model Test applications this total includes the project narrative, budget narrative, financial analysis, and operational plan. For Model Design, this total includes the project narrative, budget narrative, financial analysis, and operational plan. The maximum page limit includes all supporting materials, including documentation related to financial projections, profiles of

participating organizations, etc. In addition, states should submit letters of support from other payers and stakeholders. The standard forms, project abstract, Governor’s letter of endorsement, and attestations of support from other payers and stakeholders are NOT included in the page limits.

The state must ensure that its submission meets the technical requirements outlined above. Failure to adhere to these technical requirements may exclude an application from consideration for a cooperative award.

D. Application Content and Structure

Standard Forms

The following standard forms must be completed with an electronic signature and enclosed as part of the proposal. Failure to submit these forms will result in the application not being reviewed:

- a. SF 424: Official Application for Federal Assistance (see note below)
- b. SF 424A: Budget Information Non-Construction
- c. SF 424B: Assurances-Non-Construction Programs
- d. SF LLL: Disclosure of Lobbying Activities
All applicants must submit this document. If your agency does not engage in lobbying, please insert “Non-Applicable” on the document and include the required Authorized Organizational Representative (AOR) name, contact information, and signature.
- e. Project Site Location Forms(s)
- f. Project Abstract Summary (see description below)

Note: On SF 424 “Application for Federal Assistance”:

- a. On Item 11 “Descriptive Title of Applicant’s Project”, state the specific cooperative agreement opportunity for which you are applying: State Innovation Models.
- b. **For Item 15 please provide a succinct descriptive title of the applicant’s project. Please do not add attachments in Item 15.**
- c. Check “No” to item 16b, as Review by State Executive Order 12372 does not apply to these cooperative agreements.

Governor’s Letter of Endorsement

A letter from the Governor (or Mayor, if from the District of Columbia) endorsing the project and identifying the title of the project, the principal contact person and the major partners, departments, and organizations collaborating on the project. The letter (addressed as below) must be uploaded in the application. The original signed letter must be sent to the following address:

Gabriel Nah
Grants Management Specialist
Office of Acquisition and Grants Management
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Mailstop # 7700 Bethesda
5600 Fishers Lane
Rockville, MD 20857

Project Abstract

The one-page abstract (single-spaced) must succinctly describe the proposal and should include the goals of the proposal; the total budget; the number of included beneficiaries, providers, and payer participants; the projected total cost of care savings; and a description of how the funds will be used. The abstract is often distributed to provide information to the public and Congress, so it must be written in a manner that it is clear, accurate, concise, and without reference to other parts of the application. Personal identifying information should be excluded from the abstract.

Model Test Proposal

The application proposal for Model Test applications must address the elements outlined in Chart 2 below.

CHART 1: Application Package, Model Test Applications

MODEL TEST APPLICATIONS	Maximum Pages
i. Model Test Project Narrative (29) maximum pages in total for parts 1-9. All Sections of the Project Narrative must be clearly labeled with the title of the section, in accordance with order shown in this chart.	18 pages total for Section i.1-5 of the Project Narrative

<p>Parts 1-5 of Project Narrative: The state must produce a detailed and fully developed proposal capable of creating state-wide health transformation for the preponderance of care within the state. For each individual element and/or program in the proposal, the state must highlight how the element or program will (1) improve population health; (2) transform the health care delivery system; and/or (3) decrease per capita health care spending, drawing on a supporting evidence base.</p> <p>At minimum, each proposal must include the following core elements:</p> <ol style="list-style-type: none">(1) <i>Plan for Improving Population Health.</i> The state must provide plans to develop a state-wide plan in population health. Detailed requirements for this plan are described in Section I.4.A.i.1 of the Funding Opportunity Description and Appendix 1.(2) <i>Health Care Delivery System Transformation Plan.</i> The state must describe in detail how it will engage providers in health care delivery system transformation across the state, as described in Section I.4.A.i.2 of the Funding Opportunity Description.(3) <i>Payment and/or Service Delivery Model.</i> The state must propose one or more specific payment and/or service delivery models that include, but are not limited to, the state’s Medicaid population, state employee population, and/or commercial payers’ populations. The payment and/or service delivery models must identify the targeted populations, the number of beneficiaries served, the number of participating providers, and the services to be delivered. Any proposals that request Medicare’s participation in state-sponsored payment and/or service delivery models must adhere to the limitations described in Section I.4.A.i.3 of the Funding Opportunity Description.(4) <i>Leveraging Regulatory Authority.</i> The state must commit to using multiple regulatory authorities to influence the structure and performance of the state’s health care system. See Section I.4.A.i.4 of the Funding Opportunity Description for a discussion of regulatory authorities whose uses are envisioned under SIM.(5) <i>Health Information Technology.</i> The state must document the current state of health information technology adoption and utilization in the state (including currently EHR adoption levels, percentage of providers meeting Meaningful Use requirements in the EHR Incentive Programs, and use of technology to support HIE activities) and provide detailed descriptions for health information technology plans across Governance, Policy, Infrastructure, and Technical	(continued on next page)
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<p>Assistance domains. Detailed requirements are established in Section I.4.A.i.5 of the Funding Opportunity Description and Appendix 2.</p> <p>Further, the State must address its rationale for how the specified elements and/or programs, in combination, will achieve state-wide health transformation.</p> <p>The state may elect to focus on select areas of the state and/or to sequence elements or programs in the test geographically or temporally. The state should clearly identify the test’s geographic scope in this section and address any sequencing of individual elements and/or programs in its Operational Plan.</p>	
<p>Part 6 of Project Narrative: Stakeholder Engagement. The state must demonstrate how it will use its unique role as a stakeholder convener to accelerate state-wide health transformation. The state must (1) demonstrate that there are a significant number of key stakeholders representative of the entire state population engaged and actively committed to the implementation of the state’s Model Test proposal and (2) present a clear and pragmatic strategy for maintaining stakeholder commitment to implementation of the proposed test. Stakeholders must include health care providers/systems, commercial payers/purchasers, state hospital and medical associations, community-based and long term support providers, consumer advocacy organizations, and, as applicable, tribal communities.</p>	<p>3 pages total for Section i.6 of Project Narrative</p>
<p>Part 7 of Project Narrative: Quality Measure Alignment. The state must provide a proposal to develop a state-wide plan to align quality measures across all payers in the state. If the state and key stakeholders have not yet reached consensus on such a plan at the time of submission, the proposal must describe in detail any progress to date on quality measure alignment, including the successes and challenges faced, and must articulate a path for developing a realizable plan by the conclusion of the up to 12 month pre-implementation period. The plan should also demonstrate the payers’ commitment to reducing the administrative burden to providers in the state.</p>	<p>3 pages total for Section i.7 of Project Narrative</p>
<p>Part 8 of Project Narrative: Monitoring and Evaluation Plan. The</p>	

<p>state must provide quantifiable measures for regularly monitoring the impact of its proposed model, including the effectiveness of the policy and regulatory levers applied under the Model Test, on the three key outcomes of (1) strengthening population health; (2) transforming the health care delivery system; and (3) decreasing per capita health care spending. Measures should be selected with a focus on the particularized state health demographics and health needs the Model Test proposal aims to address. All quality and cost measures must use the state’s entire population in the denominator.</p>	<p>4 pages total for Section i.8 of Project Narrative</p>
<p>Part 9 of Project Narrative: Alignment with State and Federal Innovation. The state must identify all existing health care innovation initiatives occurring within the state, including CMS, HHS, federal, and external initiatives (e.g. Robert Wood Johnson Foundation Aligning Forces for Quality), and demonstrate how the proposal aligns with these health care innovation efforts. The state must describe how the proposal will (1) coordinate with and build upon existing initiatives and (2) ensure that federal funding will not be used for duplicative activities, or to supplant current federal or state funding.</p>	<p>1 page total for Section i.9 of Project Narrative</p>
<p>ii. Budget Narrative The State must provide a summary budget and expenditure that summarizes all Model Test expenditures, and provides the following budget and expenditure plan detail:</p> <ul style="list-style-type: none"> A. Personnel cost (Itemized) B. Fringe benefit cost C. Contract and vendor services cost (itemize by type) D. Equipment cost E. Travel, training, hotel cost (note - states must budget for attending SIM workshops and conferences) F. Supplies and miscellaneous G. System and/or data collection cost H. State evaluator costs I. Other (Itemized) J. Indirect or overhead charge to the project. Indirect charges, in 	<p>12 pages total for Section ii. Budget Narrative</p>

<p>compliance with 2 CFR Part 225 (previously OMB Circular A-87). For this Cooperative Agreement the indirect charge level is capped at 10 percent. If requesting indirect costs in the budget, a copy of the indirect cost rate is required.</p> <p>K. Other grants, revenues or in-kind services or resources that will be applied to the implementation and testing of the model, including support from other parties.</p> <p>L. Expected or needed funding from other Federal sources.</p> <p>M. Attestation that Innovation Center funding will not supplant any other funding sources</p> <p>N. Budget to collect data (including Medicaid/CHIP claims and cost data) and perform continuous quality improvement (monitoring and rapid cycle evaluation</p>	
<p>iii. Financial Analysis. The State must submit a Financial Analysis that:</p> <p>A. Describes the populations being addressed and their respective total medical costs as per member per month and population total including expected or needed funding from other sources.</p> <p>B. Describes anticipated cost savings resulting from specified interventions, including the types of costs that will be affected by the model and the anticipated level of improvement by target population and basis for expected savings (previous studies, experience, etc.)</p> <p>C. Describes expected total federal cost savings and return on investment during the project period for the overall state model. Note the CMS Office of the Actuary will review and assess the reasonableness of achieving the cost savings in these documents and this review will be considered in the selection process.</p> <p>The Financial Analysis must be accompanied by an external actuarial certification from a qualified actuary who is a member of the American Academy of Actuaries.</p>	<p>4 pages total for Section iii. Financial Analysis</p>
<p>iv. Operational Plan. The state must submit a detailed Operational Plan that describes the activities and budgets for each year of the model and provides a detailed timeline for implementation and major milestones for successfully executing the Plan. The Operational Plan</p>	<p>10 pages for Section iv. Operational Plan</p>

<p>must show how the applicant plans to scale implementation activities to ramp up to an operational start within twelve months of receiving funding. The applicant must also establish accountability targets for the project, including specific quarterly milestones and metrics associated with each investment or activity that would be financed in whole or in part by this award. Projected quarterly targets for the test period should indicate the number and/or proportion of health care providers, hospitals, and beneficiaries that will be engaged by each Model Test component. The Operational Plan must also address any assumptions made and risks to the operational timeline, and projected strategies for mitigating identified risks.</p> <p>In addition, the application should show that the applicant has the resources and track record needed to operate the model and report on the progress it is making during the operation. Applicants also should include a list of key personnel; for each person on this list, applicants should describe their relevant background, their roles, and overall responsibility. Applicants should address the Governor’s existing and future involvement in the model’s design and implementation, and the state agencies and/or departments that will be actively involved in executing the model.</p>	
<p>MAXIMUM NUMBER OF PAGES FOR MODEL TEST APPLICATIONS</p>	<p>55 pages</p>
<p>I. Standard Forms</p>	<p>As many as needed.</p>
<p>II. Project Abstract</p>	<p>1 page</p>
<p>III. Governor’s Letter of Endorsement</p>	<p>2 pages</p>
<p>IV. Attestations of Support from Identified Stakeholders</p>	<p>As many as needed.</p>

CHART 2: Application Package, Model Design Proposals

<p style="text-align: center;">APPLICATION PACKAGE, MODEL DESIGN PROPOSALS</p>	<p style="text-align: center;">Maximum Pages</p>
<p>i. Model Design Project Narrative (15) maximum pages in total for parts 1-9. All Sections of the Project Narrative must be clearly labeled with the title of the section, in accordance with order shown in this chart.</p> <p><i>Parts 1-5 of Project Narrative:</i> The state must demonstrate a clear process for designing a plan with the engagement of multiple components of state government. The state should address the elements detailed in “Proposal Requirements: Model Test Project Narrative” in Section I.4.A.i.1-9 of the Funding Opportunity Description and listed by name below, including specifically identifying the levers the state will aim to incorporate into a comprehensive state plan, such as the state’s Medicaid program, state employee health plans, and state-owned academic medical centers. In their design plans, states must explain the unique features of their design efforts and their strategies for designing a plan that aligns with existing CMS efforts. Further, state plans must include multiple payers. Round 1 Model Design states applying for Round 2 Model Design funding must describe the current state plan and clearly articulate how Round 2 strategies will enhance the existing state plan for delivery transformation. Refer to Proposal Requirements 4Ai for the following:</p> <ul style="list-style-type: none"> (1) Population Health Plan (2) Health Care Delivery System Transformation Plan (3) Payment and/or Service Delivery Model (4) Leveraging Regulatory Authority (5) Health Information Technology 	<p style="text-align: center;">10 pages for Section i.1-5 of Project Narrative</p>
<p><i>Part 6 of the Project Narrative: Stakeholder Engagement.</i> The application must identify the proposed stakeholders that will actively participate in the Model Design process and present a clear and pragmatic strategy for engaging and maintaining their commitment to developing a State Health System Innovation Plan. States are expected to work with a broad group of stakeholders representative of the entire state population in their Model Design process, including, but not limited to, a</p>	<p style="text-align: center;">2 pages for Section i.6 of Project Narrative</p>

<p>significant number of health care providers/systems, commercial payers, state hospital and medical associations, long term services support providers, tribal communities and consumer advocacy organizations. Stakeholders should represent the stated priorities of the application. The state must describe the strategy for designing a state health plan that includes multi-payer payment innovation and measure alignment. Round 1 Model Design states applying for Round 2 Model Design funding must also describe the level of engagement of stakeholders in Round 1 as well as the level of engagement expected of stakeholders in Round 2.</p>	
<ul style="list-style-type: none"> (7) Quality Measure Alignment (8) Monitoring and Evaluation Plan (9) Alignment with State and Federal Innovation 	<p>3 pages for Section i.7-9 of Project Narrative</p>
<p>ii. Budget Narrative</p> <p>The State must provide a summary budget and expenditure that summarizes all Model Design expenditures, and provides the following budget and expenditure plan detail:</p> <ul style="list-style-type: none"> A. Personnel costs (itemized) B. Fringe benefit costs C. Itemized description of contractors and/or vendor services and costs D. Travel and training costs E. Other costs (itemized) F. Indirect or overhead costs not itemized above (in compliance with 2 CFR Part 225 (previously OMB Circular A-87). For this Cooperative Agreement the indirect charge level is capped at 10 percent. If requesting indirect costs in the budget, a copy of the indirect cost rate is required. G. Total funding requested H. Total other revenue or in-kind support; identify the sources of other funding. I. Equipment J. Attestation that Innovation Center funds will not supplant funding from other sources 	<p>5 pages for Section ii. Budget Narrative</p>

<p>Round 1 Model Design states applying for Round 2 Model Design funding must describe how this proposal will enhance the existing state plan for delivery transformation.</p>	
<p>iii. Financial Analysis. The state must provide a Financial Analysis that:</p> <ul style="list-style-type: none"> A. Describes the populations being addressed and their respective total medical and other services costs as per member per month and population total; B. If known, describe anticipated cost savings resulting from specified interventions, including the types of costs that will be affected by the model and the anticipated level of improvement by target population <p>If known, describe expected total cost savings and return on investment for the overall state model and basis for expected savings (previous studies, experience, etc.).</p>	<p>2 pages for Section iii. Financial Analysis</p>
<p>iv. Operational Plan. The state must submit a detailed Operational Plan that describes the activities and budgets for the performance period of the award and a detailed timeline for the design process with major milestones. The plan should also include roles and responsibilities of key partners and payer participants (if applicable) and major milestones and dates for successfully executing the Operational Plan. Applicants also should include a list of key personnel; for each person on this list, applicants should describe their relevant background, their roles, and overall responsibility. Applicants should address the Governor’s existing and future involvement in the model’s design and implementation, and the state agencies and/or departments that will be actively involved in designing the model.</p> <p>The operational plan must also address any assumptions made and risks to the operational timeline, and projected strategies for mitigating identified risks.</p>	<p>5 pages for Section iv. Operational Plan</p>

MAXIMUM NUMBER OF PAGES FOR MODEL DESIGN APPLICATIONS	27 pages
I. Standard Forms	As many as needed.
II. Project Abstract	1 page
III. Governor’s Letter of Endorsement	2 pages
IV. Letters of support and participation from major stakeholders	As many as needed.

Budget Narrative and Expenditure Plan (see Appendix 3 for more details)

Under this cooperative agreement funding opportunity, the application must include a budget for each year of the project period (as applicable). For Model Test applications, a four-year budget must be submitted. Project proposals should include leveraging other funding resources, including private payers, foundations, ACA supported demonstrations and models, other federal funding resources, and other Innovation Center opportunities (as allowed by law). The expected or needed amount of funding from other sources should be included in the budget. Overhead and administrative costs must be reasonable, with a strong focus on operational implementation of the model. Budget and Expenditure Plans should include the cost of data collection, performance monitoring, and project expenditure reporting. Note: states cannot use funding from this initiative to supplant other funding sources. States need to show how their models will be sustainable after the testing period is complete. Applicants cannot use funding from this initiative to pay for any expenses associated with the application and selection process, including any associated travel expenses.

All state applicants must submit a form SF-424A and a Budget Narrative. The Budget Narrative must include a yearly breakdown of costs for the entire project period. Specifically the Budget Narrative should provide a detailed cost breakdown for each line item outlined in the SF 424A by year, including a breakdown of costs for each activity/cost within the line item. The proportion of cooperative agreement funding designated for each activity should be clearly outlined. The Budget Narrative should

reflect the organization's readiness to receive funding, and provide complete explanations and justifications for the proposed cooperative agreement activities. The budget must separate out funding that will be administered directly by the awardee from any funding that will be subcontracted. For more information on creating a budget narrative, please see *Appendix 3, Preparing a Budget Request and Narrative in Response to SF-424A*.

All applicants must submit an SF-424A. To fill out the budget information requested on form SF-424A, review the general instructions provided for the SF-424A and follow the instructions outlined below.

Section A – Budget Summary

- *Grant Program Function or Activity* (column a) = Enter “State Innovation Models” in row 1.
- *New or Revised Budget, Federal* (column e) = Enter the Total Federal Budget Requested for the project period in rows 1 and 5.
- *New or Revised Budget, Non-Federal* (column f) = Enter Total Amount of any Non-Federal Funds Contributed (if applicable) in rows 1 and 5.
- *New or Revised Budget, Total* (column g) = Enter Total Budget Proposed in rows 1 and 5, reflecting the sum of the amount for the Federal and Non-Federal Totals.

Section B – Budget Categories

Enter the total costs requested for each Object Class Category (Section B, number 6) for each year of the project period.

- Column (1) = Enter Year 1 Model Design or Model Test costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for direct and indirect charges for all year 1 line items should be entered in column 1, row k (sum of row i and j).
- Column (2) = Enter Year 2 Model Test costs (if applying for Model Test funding) for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for direct and indirect charges for all year 2 line items should be entered in column 2, row k (sum of row i and j).
- Column (3) = Enter Year 3 Model Test costs (if applying for Model Test funding) for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for all year 3 line items should be entered in column 3, row k (sum of row i and j).
- Column (4) = Enter Year 4 Model Test costs (if applying for Model Test funding) for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for all year 4 line items should be entered in column 3, row k (sum of row i and j).

- Column 5 = Enter total costs for all years of the project period for each line item (rows a-h), direct total costs (row i), and indirect costs (row j). The total costs for all line items for the project period should be entered in row k (sum of row i and j). The total in column 5, row k should match the total provided in Section A – Budget Summary, New or Revised Budget, column g, row 5.

Illustrative List of Allowable Model Test Costs

Allowable costs associated with state Model Test work could include:

- Technical resources necessary to implement new models
- Model performance data collection, analysis, reporting cost
- Data center costs, and system information processing associated with the Model Test
- Provider costs for data collection
- Coordination with Innovation Center rapid cycle evaluation, and costs for collecting and preparing data for Innovation Center evaluator and/or state evaluator
- Staff resources associated with model management and project management, including travel to SIM workshops and conferences
- Simulation and modeling cost
- Provider and beneficiary data management system cost
- Costs of certified EHR technology/applications to support the state’s health transformation plan for providers ineligible for the Medicare/Medicaid EHR Incentive Programs.
- Health information exchange costs associated with the model
- Infrastructure costs to build or expand telemedicine system
- Model beneficiary assignment or reconciliation cost
- Web and internet collaborative learning and communication cost
- Project management and reporting cost
- Business operation associated with the model
- Model contract management and administration
- Building a statewide all-payer database
- Impact model evaluation data collection, reporting, beneficiary and provider survey data, and other costs associated with final model evaluation
- In addition, on a limited, case-by-case, basis CMS may consider funding provider payments for performance-based shared savings.
- Other activities necessary to implement the overall State Health System Innovation Plan that will further the testing of payment and service delivery models and improve outcomes for Medicare, Medicaid and CHIP beneficiaries.

Illustrative List of Allowable Model Design Costs

Allowable costs associated with state Model Design work could include:

- State staff costs to engage in model design
- Staff participation and travel to relevant learning collaboratives and workshops and other relevant learning and diffusion opportunities
- Investments in State data collection and analysis capacity and cost and utilization pattern analysis
- Consumer and provider engagement and focus group costs
- Actuarial modeling
- Performance measure development and evidence-based improvement research
- Business process analysis and requirement system analysis
- Policy, legal, and regulatory research to address legislative and legal frameworks for models
- Planning and convening for creating a statewide all-payer data-base
- Planning work relating to public health programs including the state's Healthy People 2020 plan, and meeting goals for the National Quality Strategy and/or National Prevention Strategy
- Model Design costs, including:
 - Model scope development
 - Theory of action development
 - Target population research
 - Setting performance targets
 - Financial analysis and analysis of health care trend impacts
 - Budget planning
 - Travel to SIM workshop and conferences

States should consider the most efficient use of funds within the range of award amounts when developing a proposal.

3. Submission Dates and Times

All cooperative agreement applications must be submitted electronically and be received through <http://www.grants.gov> by 5:00 pm Eastern Daylight Time on the applicable due date. Please see the Cover Page or Overview Information on page 1 for the specific application due date.

4. Intergovernmental Review

Applications for these cooperative agreements are not subject to review by states under Executive Order 12372, "Intergovernmental Review of Federal Programs" (45 CFR 100).

Please check box “C” on item 19 of the SF 424 (Application for Federal Assistance) as Review by State Executive Order 12372, does not apply to these cooperative agreements.

5. Funding Restrictions

Indirect Costs

If requesting indirect costs, an Indirect Cost Rate Agreement will be required. For this Cooperative Agreement funding opportunity indirect costs are limited to 10%.

The provisions of 2 CFR Part 225 (previously OMB Circular A-87) govern reimbursement of indirect costs under this solicitation. A copy of these cost principles is available online at: http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&tpl=/ecfrbrowse/Title02/2cfr225_main_02.tpl.

Direct Services

Cooperative Agreement funds may not be used to provide individuals with services that are already funded through Medicare, Medicaid, and/or CHIP

Reimbursement of Pre-Award Costs

No cooperative agreement funds awarded under this solicitation may be used to reimburse pre-award costs.

Prohibited Uses of Cooperative Agreement Funds

- To match any other Federal funds.
- To provide services, equipment, or support that are the legal responsibility of another party under Federal or state law (e.g., vocational rehabilitation, criminal justice, or foster care) or under any civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.
- To supplant existing Federal state, local, or private funding of infrastructure or services.
- To be used by local entities to satisfy state matching requirements.
- To pay for the use of specific components, devices, equipment, or personnel that are not integrated into the entire service delivery and payment model proposal.
- To lobby or advocate for changes in Federal and/or state law.

V. APPLICATION REVIEW INFORMATION

In order to receive a cooperative agreement for either Model Test or for Model Design, states must submit an application in the required format, no later than the established deadline date and time. Applications that do not meet all the technical requirements will not be reviewed.

If an applicant fails to submit all of the required documents or does not address each of the topics described below, the applicant risks not being awarded a cooperative agreement.

As indicated in Section IV, Application and Submission Information, all state applicants for Model Test awards must submit the following:

1. Standard Forms
2. Project Abstract
3. Governor's Letter of Endorsement
4. Letters of support and participation from major stakeholders
5. Project Narrative (addressing the following subject areas)
 - Population Health Plan
 - Health Care Delivery System Transformation Plan
 - Payment and/or Service Delivery Model
 - Leveraging Regulatory Authority
 - Health Information Technology
 - Stakeholder Engagement
 - Quality Measure Alignment
 - Monitoring and Evaluation Plan
 - Alignment with State and Federal Innovation
6. Budget Narrative
7. Financial Analysis
8. Operational Plan

All state applicants for Model Design awards must submit the following:

1. Standard Forms
2. Project Abstract
3. Governor's Letter of Endorsement
4. Letters of support and participation from major stakeholders
5. Project Narrative (addressing the following subject areas)
 - Population Health Plan

- Health Care Delivery System Transformation Plan
 - Payment and/or Service Delivery Model
 - Leveraging Regulatory Authority
 - Health Information Technology
 - Stakeholder Engagement
 - Quality Measure Alignment
 - Monitoring and Evaluation Plan
 - Alignment with State and Federal Innovation
6. Budget Narrative
 7. Financial Analysis
 8. Operational Plan

1. Criteria

A. Model Test

1. Expert Review Panel. Model Test applications will be reviewed by an expert review panel and scored based on the quality of the proposals. The SIM Round 2 Model Test criteria for selection are as follows:

- Model Test Plan (50 points)
 - a. Model Test applicant must demonstrate the ability to test innovative payment reforms that have the potential to accelerate transformation. The elements of the Model Test plans will be evaluated on the following criteria:
 - Well developed, detailed and clear annual cost and quality targets, which the state commits to review and report at least annually;
 - Use of policy and regulatory state levers to support successful health care transformation in the state;
 - Alignment with existing CMS programs and other state programs;
 - Number of residents directly affected by the Model Test;
 - Number of providers and payers participating in the Model Test
 - Likelihood of accelerating delivery system transformation;
 - Development and use of health IT infrastructure (See Appendix 2: Health Information Technology Plan).
 - b. As this initiative is intended to reach a preponderance of a state's population, a state's decision to expand Medicaid will be an important factor in assessing the state's readiness to implement a state-wide plan for improving population health. Additionally, because Medicaid can serve as an important lever for driving delivery transformation, states should

describe Medicaid expansion activities and the percentage of a state's population covered by Medicaid.

- c. The Model Test must offer and clearly demonstrate a pathway to a high potential for success in producing better health, better care and lower costs through improvement for Medicare, Medicaid/CHIP, and Medicare-Medicaid enrollee populations as well as other health care consumers within the state.
 - d. The model must describe in detail the target populations, geographic areas, or communities that will be the focus of Model Testing, the current quality and beneficiary experience outcomes including current health population status, and the specific improvement targets expected from the Model.
 - e. The state must identify specific implementable plans to collaborate with the CDC to develop a state-wide plan for improving population health. The plans will include developing collaborative approaches to improving population health that engage public health officials and provider organizations. (See Appendix 1: Plan for Improving Population Health).
 - f. The state must demonstrate engagement in HHS initiatives to improve health and health care delivery.
 - g. Integrated data is used not only to directly support the implementation of health care interventions but also to inform and improve the model throughout the period of the award. The state must include a clear feedback loop and strategies for continuous monitoring and improvement of the model through collection and analysis of data across payers and partners.
 - h. The state must identify strategies they will employ to leverage State Marketplace Exchanges to further advance value-based payment methodologies.
- Provider Engagement Strategy (10 Points)
The state must demonstrate a clear, sustained commitment to participation and implementation of the health transformation model of major stakeholders including but not limited to advocacy groups, local governments, social service providers, and providers of acute health care, behavioral/mental health care, long term care (including home and community services as well as long term care facility services) in the state, including but not limited to state-owned entities, providers of acute health care, behavioral/mental health care, long term care (including home and community services as well as long-term care facility services).

- Payer and Other Stakeholder Strategy (10 Points)

The state must also demonstrate participation on the part of commercial payers with respect to both financial and quality measurement alignment. The state should identify a broad group of stakeholders involved in the execution of the Model Test, including but not limited to advocacy groups, local governments and social service providers.
- Operational Plan (20 points)

States must demonstrate the organizational and operational capacity, organizational structure, leadership and expertise to successfully implement Model Test processes. The detailed project plan and timeline should be well described and clearly demonstrate how the state will successfully lead health transformation in the state with resources provided. The project leadership must clearly demonstrate the required knowledge, skills, abilities and experience to ensure efficient, smooth and effective implementation. States must also include a sustainability plan for the next 4 years beyond the period of the award that includes changes in personnel or administration as well as a clearly detailed plan for continued financing to support sustained health reform/transformation after CMMI award funding is exhausted.
- Model Test Budget Narrative and Financial Analysis (10 points)

The proposed budget is carefully developed, is consistent with the Model Test requirements, and is clearly linked to support of a successful implementation plan. Overhead and administrative costs are limited to 10% of direct costs with funding focused on direct support of the Model Test. States must indicate other specific resources that will aid in implementing the Model Test plan, including descriptions of how these resources directly support health transformation in the state. The proposal must document how the overall Financial Analysis, including population and intervention specific savings, will be developed, how return on investment will be calculated, and how the state will incorporate non-CMMI funding (particularly commitments from the multi-payer collaborators, including but not limited to other state and local government resources) into the overall health transformation plan.

Based on scores from the Expert Panel Review, selected applicants will be invited to present in person (in the Baltimore/Washington Metropolitan area) to an HHS Leadership Panel (see Section I.4.A. *Model Test: Proposal Requirements* for more information). **The HHS Leadership Panel members are individuals who possess knowledge or expertise in innovative health care payment and service delivery models. They will review the applications prior to the presentations, consult during the presentations,**

and subsequently provide advice to the approving official. The presentations will help to ensure that only those applications that offer the greatest potential for furthering program purposes are selected for funding. The presentations will include the information from the FOA but will also be expected to highlight the following:

- State and Stakeholder Commitment

States must demonstrate a commitment by a broad coalition of stakeholders, including state leadership, during the in-person presentation. The role and contribution of each stakeholder will be considered.

- Likelihood of Success

States must demonstrate that their specific approach, through the joint efforts of stakeholders, will be likely to result in achieve success by reducing costs, improving quality and promoting delivery system transformation.

- Novelty of Payment Model

State should demonstrate how their payment model presents a unique approach to delivery reform that would accelerate delivery transformation in a manner that has not been test on a state-wide scale.

- Ability to Align with Medicare Programs

States should articulate how their proposal would align with existing CMS programs. For example, a multi-payer ACO approach could complement and align with the Medicare Share Savings program. State could also demonstrate how this alignment will further delivery transformation and reduces costs and improve care for all-payers, including Medicare.

B. Model Design

Model Design applications will be reviewed and scored based on the quality of the proposals. **In-person presentations are not required for the Model Design applicants.** The criteria for Round 2 Model Design selection as follows:

- Model Design Strategy (30 points)

States must demonstrate a clear process for designing a plan with the engagement of multiple components of state government and with key stakeholders. The design strategy should specifically identify the levers the state would seek to

develop and incorporate into a comprehensive state plan, such as the state's Medicaid program, state employee health plans, state-owned academic medical centers, etc. States must explain the unique features of their design efforts and their strategy for designing a plan that aligns with existing CMS efforts and can be implemented on a multi-payer basis. States should demonstrate efforts to improve access to care to vulnerable populations. States should also include strategies that leverage State Marketplace Exchanges in expanding value-based payment methodologies. As this initiative is intended to reach a preponderance of a state's population, a state's decision to expand Medicaid will be an important factor in assessing its potential impact. Continuing Round 1 Model Design states must demonstrate progress in developing their design plans and clearly articulate how proposed strategies will enhance their Round 1 efforts.

- **Provider Engagement Strategy** (15 Points)
States must demonstrate the commitment of major providers of health care in the state, including behavioral/mental health care, long term care providers and state-owned entities, behavioral/mental health care, long-term care, and long-term services and supports, to participate in the design of the State Health System Innovation Plan. Continuing Round 1 Model Design states must demonstrate appreciable progress to date in engaging providers.
- **Payer and other Stakeholder Engagement Strategy** (15 points)
The state must describe its strategy for designing a State Health System Innovation Plan that includes multi-payer payment innovation and measure alignment. The design of these aspects of the plan must include the participation of commercial payers and purchasers as well as various stakeholders, including state health associations and advocacy groups. States are expected to identify a broad group of stakeholders and create a mechanism for their effective participation in planning of the State Health System Innovation Plan and document the development of a multi-payer Model Design with stakeholder input. Round 1 Model Design states must demonstrate results in engaging payers and other stakeholders.
- **Operational Plan** (10 points)
The state must demonstrate the organizational capacity, organizational structure, leadership, and expertise to successfully complete the Model Design process. The project plan and timeline should be detailed and well described. The staff or consultants proposed to lead the planning effort should have the skills and experience needed to ensure smooth and effective implementation.
- **Model Design Budget Narrative and Financial Analysis** (30 points)

The proposed budget is carefully developed and consistent with the Model Design requirements. Overhead and administrative costs are reasonable (limited to 10% of direct costs) with funding focused on supporting the Model Design effort. States should indicate other resources that will aid in designing the State Health System Innovation Plan. The proposal should document how the overall Financial Analysis, including population and intervention specific savings, will be developed.

Part of the review process will include an analysis of the readiness of the state to complete the design process within one year after approval of a cooperative agreement award.

2. Review and Selection Process

There will be separate review processes for Model Test and Model Design. CMS will work closely with the applicant to determine the appropriate funding amount. The review process will include the following:

- Applications will be screened for completeness and adherence to eligibility requirements for the category states' have applied for: Model Test or Model Design. Applications received late or that fail to meet the eligibility requirements detailed in this solicitation or do not include the required forms will not be reviewed.
- An objective review panel will determine the merits of the proposal and the extent to which the proposed model furthers the purpose of SIM, in accordance with the information outlined in Sections I. and IV. of this funding opportunity announcement and the criteria specified in Section V. The objective review panel may include federal employees and/or non-federal employees.
- For Model Test states, applicants will be required to present their proposals to HHS leadership as part of the selection process. The purpose(s) of the presentation is(are) to:
 - determine the extent to which the proposed model furthers the purpose of SIM, in accordance with the information outlined in Sections V.
 - determine the commitment of the state in implementing the proposal.
 - determine the level of commitment and investment by stakeholders.
 - assist CMS in its assessment of factors such as proposal feasibility, stakeholder engagement and state leadership.
- assist CMS in understanding the number of individuals impacted by the proposal.

The state's presentation must be led by a cabinet-level health official, such as a State Secretary of Health, and include providers and commercial payers who have committed to participate in the model. In the case of public-private partnership entities applying for a State Innovation Model Test award, senior leaders from the private and public sector, including senior leaders of the applicant entity, shall be present. Specifically, CMS expects applicants to address the criteria set forth in this FOA. CMS will also consider the number and nature of participation by stakeholders, including providers and payers, in the presentation. CMS may require further discussions with states regarding their proposals.

- For Model Test applications, the CMS Office of the Actuary will provide an assessment of the reasonableness of the state's savings estimates. CMS reserves the right to request that state applicants respond to feedback provided by this office through programmatic or budgetary revisions.
- Following the end of the review processes described above, the approving CMS official will make the final award decisions taking into consideration:
 - the recommendations of the objective review panel;
 - the performance review of the presentation made by state and stakeholders;
 - if applicable the state's response to CMS' request to meet additional requirements or make plan amendments;
 - the geographical diversity of awardees;
 - the readiness of the state to conduct the work required for Model Test proposal;
 - the range of service delivery and payment models proposed;
 - the scope of impact across different state population segments;
 - reviews for programmatic and grants management compliance;
 - the reasonableness of the estimated cost to the government and anticipated results;
 - the net Federal savings potential over the project period as reviewed and verified by OACT;
 - the likelihood that the proposed Model will result in the benefits expected, including a positive return on investment;

- novelty of payment model; and
 - applicant's response to budget negotiations.
- If OACT assesses the state's potential for savings and determines that a state's model is not likely to achieve significant savings, the CMS approving official has the right to also take this factor into consideration in making final award decisions.
 - Successful state applicants will receive one cooperative agreement award issued under this announcement for the appropriate funding category: Model Design or Model Test. CMS reserves the right to approve or deny any or all proposals for funding. Note that Section 1115A of the Social Security Act specifies that there is no administrative or judicial review of the selection of organizations, sites, or participants to test models.
 - If a Model Test applicant is not selected for a Model Test award, CMS may select the state/entity for a Model Design award if (1) after all possible states/entities which applied for Model Design awards are selected and funding is still available to issue additional Model Design awards (not to exceed overall maximum of 15 Model Design awards); and (2) CMS determines the state/entity is not ready for a Model Test award and would benefit from Model Design funding.

VI. AWARD ADMINISTRATION INFORMATION

1. Award Notices

Successful applicants will receive a Notice of Award (NoA) signed and dated by the CMS Grants Management Officer. The NoA is the document authorizing the cooperative agreement award and will be issued to the applicant organization as listed on the SF424 and available to the organization through the online grants management system used by CMS and awardee organizations. Any communication between CMS and applicants prior to issuance of the NoA is not an authorization to begin performance of a project, and any expenses incurred prior to the project start date will not be reimbursed.

Unsuccessful applicants are notified within 30 days of the project start date for each cooperative agreement and will receive a disapproval letter via the U.S. Postal Service and/or electronic mail.

2. Administrative and National Policy Requirements

The following standard requirements apply to applications and awards under this FOA:

- Specific cost principles and administrative requirements, as outlined in 2 CFR Part 225 and 45 CFR Part 92, apply to cooperative agreements awarded under this announcement.
- All awardees under this project must comply with all applicable Federal statutes relating to nondiscrimination including, but not limited to:
 - Title VI of the Civil Rights Act of 1964,
 - Section 504 of the Rehabilitation Act of 1973,
 - The Age Discrimination Act of 1975, and
 - Title II Subtitle A of the Americans with Disabilities Act of 1990.

All equipment, staff, other budgeted resources, and expenses must be used exclusively for the project identified in the state's original cooperative agreement application or agreed upon subsequently with HHS, and may not be used for any prohibited purposes.

3. Terms and Conditions

Cooperative agreements issued under this FOA are subject to the *Health and Human Services Grants Policy Statement (HHS GPS)* at <http://www.hhs.gov/asfr/ogapa/aboutog/hhsgps107.pdf>. Standard terms and special terms of award will accompany the Notice of Award. Potential awardees should be aware that special requirements could apply to awards based on the particular circumstances of the effort to be supported and/or deficiencies identified in the application by the HHS review panel. The General Terms and Conditions that are outlined in Section II of the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary (as specified in the Notice of Award).

4. Cooperative Agreement Terms and Conditions of Award

The following categories of special terms of award are in addition to, and not in lieu of, otherwise applicable OMB administrative guidelines, OMB cost principles at 2 CFR Part 225 (previously OMB Circular A-87), HHS grant administration regulations at 45 CFR Part 92 (Part 92 is applicable when state and local Governments are eligible to apply), and other HHS and PHS grant administration policies. CMS reserves the right to include any of the terms outlined below in the cooperative agreement with an appropriate level of specific details:

- Reporting (financial, quality, operational and accountability targets progress)

- Learning and Diffusion (training)
- Stakeholders (public notice, tribal consultation)
- Beneficiaries (access, enrollment, change in rights)
- Providers (approval of training)
- Payers (rate setting, marketing)
- Project Monitoring (contract review, audits)
- Data Collection (data integrity, use of data)
- Evaluation (rapid cycle and impact)
- Termination
- Funding
- Financial Arrangements
- Operations (information technology, claims, personal health information)
- Program Integrity

The administrative and funding instrument used for this program will be a cooperative agreement, an assistance mechanism in which substantial CMS programmatic involvement with the State is anticipated during the performance of the activities. Under each cooperative agreement, CMS' purpose is to support and stimulate the state's activities by involvement in and otherwise working jointly with the award state in a partnership role. To facilitate appropriate involvement during the period of this cooperative agreement, CMS and the state will be in contact monthly and more frequently when appropriate.

Cooperative Agreement Roles and Responsibilities are as follows:

Centers for Medicare and Medicaid Services

CMS will have substantial involvement in program awards, as outlined below:

- Technical Assistance: CMS will provide technical assistance throughout the period of the cooperative agreement.
- Collaboration: To facilitate compliance with the terms of the cooperative agreement and to more effectively support states, CMS will actively coordinate with certain critical stakeholders, such as: state-designated entities and other relevant federal agencies including but not limited to the Centers for Disease Control, the Administration for Community Living, the Substance Abuse and Mental Health Services Administration, the Health Resources and

Services Administration, the U.S. Office of Personnel Management, the Indian Health Service, the Internal Revenue Service, the Department of Homeland Security, the Administration for Children and Families, the Department of Veterans Affairs, and the Social Security Administration.

- Program Evaluation: CMS will work with states to implement lessons learned to enable other states to undertake health transformation plans.
- Progress against the Model Test and Model Design Work Plans: CMS will evaluate grant performance and progress against the state's operational plan and will allow access to funding in alignment with state progress.
- Project Officers and Monitoring: CMS will assign specific Project Officers to each Cooperative Agreement award to support and monitor States throughout the period of performance. HHS Grants Management Officers and Project Officers will monitor, on a regular basis, progress of each State. This monitoring may be by phone, document review, on-site visit, other meeting and by other appropriate means, such as reviewing program progress reports and Federal Financial Reports (SF425). This monitoring will be to determine compliance with programmatic and financial requirements.
- Conference and Training Opportunities: CMS will host opportunities for training and/or networking, including conference calls and other vehicles.

States

States and assigned points of contact retain the primary responsibility and dominant role for planning, directing and executing the proposed project as outlined in the terms and conditions of the Cooperative Agreement and with substantial CMS involvement. States shall:

- Requirements: comply with all current and future requirements for Model Test and/or Model Design.
- Collaboration: collaborate with the critical stakeholders listed in this funding opportunity and the HHS team, including the assigned Project Officer. States are also required to collaborate with their state Medicaid Directors, state Insurance Commissioners, and other key state stakeholders such as state developmental disabilities directors, aging directors, HIT coordinators, mental health directors, substance abuse directors, etc.
- Reporting: comply with all reporting requirements outlined in this funding opportunity and the terms and conditions of the cooperative agreement to ensure the timely release of funds.
- Program Evaluation: cooperate with Innovation Center directed evaluations.

5. Reporting

The Innovation Center will take an active and substantial role in the evaluation and monitoring of SIM Design and Model Test awards. The activities funded under the cooperative agreement and their resulting State responsibilities will be part of performance tracking, measuring, and evaluation responsibilities of CMS and the Innovation Center. In the case of Model Design awards, CMS will examine how the states used the funds. We will examine whether the planning and design support resulted in the multiple payers and providers in the state coming together to develop a plan to transform the delivery system. To the extent that a delivery system reform plan was developed, we will examine the extent to which the plan was implemented, whether health care spending in those states changed over time, and what was the impact on health care quality.

Performance assessment, monitoring, and evaluation for Model Test awards will focus on:

- Impact on quality of care, patient experience, and health status
- Impact on health care costs
- Implementation and test performance, including:
 - Meeting proposed design and planning or implementation and test milestones.
 - Demonstrating readiness to carry out design and planning work or implementation activities required to test the proposed model.
 - Producing timely and accurate reports showing clear progress on design and planning activities or providing the required data, and/or reports on health care cost, quality, and population health performance, as delineated in the cooperative agreement.
 - Community integration of health care

A. Progress Reports

Awardees must agree to cooperate with any federal evaluation of the model and performance results and provide required quarterly, semi-annual (every six months), annual and final (at the end of the cooperative agreement period) reports in a form prescribed by CMS. Reports will be submitted electronically. These reports will include how cooperative agreement funds were used, describe project or model progress, and describe any barriers, delays, and measurable outcomes. CMS will provide the format for

project and model reporting and technical assistance necessary to complete required report forms.

States must also agree to respond to requests that are necessary for the evaluation of the Model Design or Model Test efforts and provide data on key elements of model performance and on results from the cooperative agreement activities. CMS will continue to make requests for data related to its evaluation beyond the end of the state's performance period. The period for which CMS may continue to make such requests will be further clarified in the terms and conditions of award.

B. Project Monitoring

CMS will enlist a third party entity to assist in monitoring the model implementation and testing performance results and outcomes. CMS plans to collect data elements to be part of monitoring for all of the different state models, and these monitoring and surveillance elements will feed into the evaluation. All awardees will be required to cooperate in providing the necessary data elements to CMS or a CMS contractor. The contractor would assist CMS in developing cost, quality, beneficiary experience, and population health monitoring and review model performance to ensure model design requirements are met; tracking performance across awardees and providing for rapid cycle evaluation and early detection of model performance issues; developing a system to collect, store, and analyze data to assess health care cost and utilization, quality performance, beneficiary experience, and population health improvements and assisting with state implementation, including coordination between states and CMS and its other contractors.

Data for monitoring will include process, safety, and performance measures including beneficiary experience. It will include, but will not be limited to, data on the background characteristics of the target population and target area, data characterizing the activities of the Model Test and a battery of follow-up data describing relevant characteristics of the target population or target area and metrics at selected intervals after commencement of the delivery system and/or payment model. This will include detailed information on participant characteristics and outcomes reported in a standard format. Data for monitoring will be collected from awardees and/or CMS claims data, electronic health record, public health or other sources. The model monitoring aspect of this initiative will balance the examination of the extent to which awardees demonstrate fidelity to their proposed delivery system and payment models and the potential need to make mid-course corrections that improve or optimize performance of the delivery system or payment models based on feedback from the monitoring and rapid cycle evaluation findings. The evaluation will also assess whether there is evidence of harm or unintended consequences as a result of the models or testing methods.

C. Evaluation

The evaluation strategy for this initiative includes three parts: an overall design and data collection phase, rapid cycle evaluation of state models, and an impact evaluation.

Broadly, CMS will evaluate each design and each state model and then compare all models to identify themes related to improved care and health outcomes and reduced costs. While states must play an active role in these evaluations, particularly in regard to Medicaid and CHIP benefits, so that these evaluation efforts continue after the model funding has ended. CMS has ultimate responsibility for the evaluation process and reports. Each state is encouraged to identify a research group, preferably within the state, that will assist in the evaluation and develop in-state evaluation expertise. An Innovation Center contractor will help develop methodological and data standards, conduct monitoring and rapid-cycle evaluation to promote real-time program improvement, and conduct the impact evaluations.

D. Evaluation Design and Data Collection

An external evaluation contractor will support the Innovation Center during the Implementation and Test process. This Innovation Center evaluator will work with each state to develop standards for data collection and use and for data reporting, as well as requirements for those data elements that will be collected by the states and reported to CMS. The Innovation Center evaluator will also define the measures to be used and evaluation methods to be employed. Data collection is central to the success of the evaluation. Adhering to the data collection requirements will be a condition of participating in this initiative.

States are expected to cooperate in the evaluation process and provide the necessary data to evaluate state models. This data will be shared with the state evaluator team and with Innovation Center evaluation contractors. The evaluation will rely on multi-pronged data collection in order to understand the context of the model and to capture the nuances occurring at the model sites. Data for the analyses will be collected collaboratively between the Innovation Center evaluation contractor and the states themselves, and will come from sources including, but not limited to: provider surveys; Medicare administrative claims; state Medicaid and CHIP programs; beneficiary experience surveys; site visits with practices; and focus groups with beneficiaries and their families and caregivers, practice staff, direct support workers and others (*e.g.*, payers). Additional data requirements may include states providing Medicaid encounter data (baseline and during the model test period) if relevant to program evaluation. The requirement for data and methods for evaluation will be finalized upon approval of the state model.

The State evaluation contractor will be expected to create State evaluations relevant to all populations and payer involved in the State initiative; data collection, storage, cleaning and creation of analytic datasets; continuous quality improvement and analysis of evaluation metrics on a quarterly basis; and working with the Innovation Center evaluator to supply necessary data. The State evaluation contractor needs to be an independent entity. The State's agreement with their evaluation contractor will be reviewed by CMS to ensure the evaluator's capabilities.

CMS will use qualitative interviews with state administrators and providers to understand the organizational structures, the approaches to overcoming barriers, and the kinds of facilitators at the state level that are associated with success.

The Innovation Center evaluation contractor will be asked to work closely with CMS to establish key measures to be used across evaluations for all models from participating states. The Innovation Center has developed a core measure set which will be enhanced to include priority metrics of success for delivering better health care, better health, and reduced cost. One particular focus of this effort will be an evaluation of the state model on population health metrics to better understand how state approaches influence broad determinants of health and the metrics of population health.

The precise analytic methods are not yet available but will depend on the state model being tested and will be determined in collaboration with the Innovation Center evaluation contractor and CMS. CMS will identify the best methodology available for the state model being implemented. Where appropriate, CMS will prefer to use an in-state control group for each state. CMS will request that states hold back a certain equivalent population that will not be enrolled in the intervention. This population can serve as a concurrent control group for the within-state evaluation. Some states may not be able to withhold the intervention from anyone within the state. In those cases, our next most preferred methodology will be to identify a control group from another state. Data collection will be an important concern for controls from outside the state. CMS may have to identify a single, large state that we will fund to collect data from Medicaid and CHIP managed care programs to be sure that we have a reliable source to identify control beneficiaries. Other methods may be considered, depending on the model being implemented and the likelihood of alternative evaluation methods yielding testable results.

For each of the measures of interest (quality, access to care, health care cost and utilization patterns, supplemental expenditures, beneficiary experience, population health and others), one of several statistical techniques will be employed to evaluate the effect of the model approach and intervention on outcomes of interest. The plan is to use difference-in-difference models or time trend analyses (segmented linear regression

models) to study the experience over time of the states relative to the comparison groups in a way that controls for as many relevant confounding variables as possible.

The Innovation Center evaluation will assess the impact of the models on the quality of care, health outcomes, community health, and net saving in total costs. Key evaluation questions for each state will include:

1. Does the model reduce expenditures in absolute terms, create net savings, and/or reduce health care cost trends? Does the model reduce or eliminate variations in utilization and/or expenditures that are not attributable to differences in health status? If so, how have they been accomplished?
2. Does the model achieve better care coordination? If so, how does the model improve care coordination and for which beneficiaries?
3. Does the model deliver better quality of care and/or improve beneficiary experiences of care and services? If so, how does the model improve quality and beneficiary experience and for which beneficiaries?
4. Did the payment model align provider behavior to continuous performance improvement and outcomes or did payment model result in any unintended consequences, including adverse selection, access issues, lower quality of care, cost shifting beyond the agreed upon episode, evidence of withholding appropriate care, anti-competitive effects on local health care markets, or evidence of inappropriate referrals practices? If so, how, to what extent, and for which beneficiaries or providers?
5. What factors are associated with the pattern of results (above)? Specifically, are they related to:
 - a. Characteristics of the models?
 - b. Characteristics of the participating providers' approach to their chosen model?
 - c. Characteristics of the participating providers' specific features and ability to carry out their proposed intervention?
 - d. Characteristics of the market or particular populations?
 - e. Programmatic changes undertaken in response to CMS-sponsored learning and diffusion activities and/or rapid-cycle evaluation results?

E. Monitoring and Rapid-Cycle Evaluation within States

The Innovation Center evaluator will conduct rapid-cycle evaluations for all CMS beneficiaries affected by the SIM initiative. These results will inform learning and

diffusion collaborations. Each state will be required to select an internal evaluation contractor as part of the application process. This in-state evaluation contractor will provide data to both CMS evaluators and the Innovation Center external evaluation contractor(s). CMS evaluators will work with the Innovation Center external contractor(s) and state evaluators to learn and adopt best practices. The goal is for states to continue these evaluations once the SIM initiative is complete.

F. Impact Evaluation

Towards the end of the Model Test, the Innovation Center evaluation contractor will conduct impact evaluations of the effectiveness of each state model on key outcomes for target Medicare, Medicaid, and CHIP beneficiaries. Again, either difference-in-difference or time trend models, using concurrent controls, will be used to evaluate the impact of the models.

The Innovation Center will attempt several approaches, as follows, to isolate the effect of each Model Test reform in the context of other interventions occurring in the state, such as ACOs and Bundled Payments:

- A conservative approach, dropping all consumers who have been subject to multiple interventions, will allow for direct comparison between intervention and control groups.
- Additional regression analyses will be conducted on consumers who are subject to multiple interventions to evaluate the incremental effects of adding one payment reform in the setting of another.
- The analyses will be repeated with interaction terms to explore whether certain combinations of reforms have disproportionately greater effects on outcomes of interest.

The Innovation Center evaluation contractor will also conduct comparative analyses and assess differences in performance between states. The goal will be to both compare the results in different states and also to look at the qualitative results in order to link contextual factors with performance. Doing so will allow the Innovation Center evaluator to better understand the relationship between different state-level strategies to coordinate care, different portfolios of interventions, and the outcomes that were measured.

This Innovation Center's impact evaluation should provide key messages about what types of state strategies are associated with success. While CMS will not be able to definitely isolate many of these strategies in Innovation Center evaluation, we will find

important relationships about how the context in which the state operates influences outcomes.

States with approved models will be responsible for including the state's contracted evaluators and for funding data collection and performance reporting in its implementation and testing budget.

Depending on the mix of awarded models, the Innovation Center evaluation will examine the proposed models independently, but will group similar models and analyze the groups accordingly. Ultimately, the evaluation results from all models will be reconciled in order to identify and characterize the most effective models to inform future policy making around improving beneficiary care, improving beneficiary health, and reducing costs.

The Innovation Center evaluator, with assistance of the awardees, will be expected to identify control/comparison groups who did not participate in one of the interventions to examine the effect of the interventions on outcomes of interest. Difference-in-difference models and segmented linear regression models with concurrent controls will be employed to examine the effects of each intervention group compared to controls. Sensitivity analyses combining similar models will also be conducted to examine broad program effects. Sensitivity analyses examining specific geographic regions will be conducted to attempt to disentangle intervention effects in sites where multiple interventions are implemented.

The Innovation Center evaluation will be sensitive to the continual need for rapid-cycle and close-to-real-time production of findings that can be used by awardees and policy makers to make decisions about programmatic changes throughout the life of the project. The Innovation Center evaluation will gather quantitative and qualitative data and use claims data to both assess real time performance and feed that information back to states for ongoing improvement. Qualitative approaches such as interviews, site visits and focus groups are envisioned in order to compare the planned and actual performance of each state's model. Multiple cycles of interviews may be necessary due to the changing nature of the models used by the states in response to rapid-cycle feedback.

G. Federal Financial Report

The Federal Financial Report (FFR or Standard Form 425) has replaced the SF-269, SF-269A, SF-272, and SF-272A financial reporting forms. All grantees must utilize the FFR to report cash transaction data, expenditures, and any program income generated.

States must report on a quarterly basis cash transaction data via the Payment Management System (PMS) using the FFR in lieu of completing a SF-272/SF272A. The

FFR, containing cash transaction data, is due within 30 days after the end of each quarter. The quarterly reporting due dates are as follows: 4/30, 7/30, 10/30, 1/30. A Quick Reference Guide for completing the FFR in PMS is at:
www.dpm.psc.gov/grant_recipient/guides_forms/ffr_quick_reference.aspx.

In addition to submitting the quarterly FFR to PMS, states must also provide, on an annual basis, a FFR to CMS which includes their expenditures and any program income generated in lieu of completing a Financial Status Report (FSR) (SF269/269A). Expenditures and any program income generated should only be included on the annually submitted FFR, as well as the final FFR. Annual FFRs must be submitted within 90 calendar days of the applicable year end date. The final FFR must be submitted within 90 calendar days of the project period end date.

More details will be outlined in the Notice of Award.

H. Transparency Act Reporting Requirements

New awards issued under this FOA are subject to the reporting requirements of the Federal Funding Accountability and Transparency Act of 2006 (Pub. L. 109–282), as amended by section 6202 of Public Law 110–252 and implemented by 2 CFR Part 170. Grant and cooperative agreement recipients must report information for each first-tier sub-award of \$25,000 or more in Federal funds and executive total compensation for the recipient’s and sub-recipient’s five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170 (available online at www.fsr.gov). Non-Competing Continuation awardees may be subject to this requirement and will be so notified in the Notice of Award.

I. Audit Requirements

States must comply with the audit requirements of Office of Management and Budget (OMB) Circular A-133. Information on the scope, frequency, and other aspects of the audits can be found on the Internet at www.whitehouse.gov/omb/circulars.

J. Payment Management Requirements

States must submit a quarterly electronic SF-425 via the Payment Management System. The report identifies cash expenditures against the authorized funds for the cooperative agreement. Failure to submit the report may result in the inability to access funds. The SF-425 Certification page should be faxed to the PMS contact at the fax number listed on the SF-425, or it may be submitted to:

Division of Payment Management
HHS/ASAM/PSC/FMS/DPM
PO Box 6021
Rockville, MD 20852
Telephone: (877) 614-5533

VII. AGENCY CONTACTS

1. Programmatic Contact Information

All programmatic questions about the SIM initiative must be directed to the program e-mail address: stateinnovations@cms.hhs.gov. This e-mail address is regularly monitored, and a response to questions will be posted on <http://innovations.cms.gov> within 48 business hours. If a response to a question is not posted within the designated timeframe, the submitter may direct a follow-up question to:

Leah B. Nash
Centers for Medicare & Medicaid Services
Center for Medicare & Medicaid Innovation
Phone: 410-786-8950 or e-mail: Leah.Nash@cms.hhs.gov

2. Administrative Questions

Administrative grant questions about the SIM initiative may be directed to:

Grants Management Specialist, Gabriel Nah
Centers for Medicare & Medicaid Services
Office of Acquisitions and Grants Management
Phone: 301-492-4482 or email: Gabriel.Nah@cms.hhs.gov

VIII. Appendices

Appendix 1: Plan for Improving Population Health

Population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group... it is understood that population health outcomes are the product of multiple determinants of health including medical care, public health, genetics, behaviors, social factors and environmental factors.

IOM Roundtable on Improving Population Health 2013

Goal:

All SIM (Design and Test States) as a condition of their funding shall develop and implement a plan to improve the health and wellbeing of the state's population (a Plan for Improving Population Health). The Plan for Improving Population Health should assess the overall health of the state and identify measurable goals, objectives and interventions that will enable the state to improve the health of the entire state population; improve the quality of health care across the state and, reduce health care costs.

The goals, objectives and strategies outlined in the Plan for Improving Population Health should align with the population health metrics that have been developed by the CMMI/CDC team in this Appendix. At a minimum the plan should address the core measures identified in the population health metrics document: tobacco, obesity and diabetes. The plan should include the evolving role of new models of health care delivery such as Patient Centered Medical Homes (PCMH), Accountable Care Organizations (ACOs) and Accountable Care Communities (ACCs) to improve population health. All interventions identified in the plan should be evidence-based and have a focus on the general population, high risk groups, and/or groups experiencing disparities in health conditions or outcomes. States may want to refer to the National Prevention Strategy (<http://www.surgeongeneral.gov/initiatives/prevention/strategy/>), the Agency for Health Care Research and Quality's Guide to Clinical Preventive Services (<http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/index.html>), or the Guide to Community Preventive Services (<http://www.thecommunityguide.org/index.html>) for a list of evidence based interventions. The Plan should include strategies that will be led by both governmental and non-governmental partners.

Goals, Objectives and Strategies:

- The Plan for Improving Population Health must:
- Include goals, objectives and interventions that are specific, measurable, achievable in the specific time period, realistic, and time bound.

- Objectives and associated interventions must address the identified priorities via interventions designed to impact both the health care delivery system and the underlying social determinants of health that contribute to the prioritized health condition.
- Include a population health needs assessment based upon the surveillance and epidemiology reports from the state and local health departments, hospital community health needs assessments, and data provided to SIM awardees from CDC. The assessment should build upon rather than duplicate these efforts.
- Describe the interventions selected, why the interventions were selected and the evidence or guidance that supports them as proven, effective, or promising. If a key need identified in the assessment is not selected, explain why not. Ideally, selected interventions will address health concerns with:
 - high population burden or societal costs;
 - have the potential to demonstrate improvement in health, quality of care and decreased costs within the next three to five years; and
 - be measurable with data for major segments of the population at the state and/or substate level.
- Be specific to the goals and the conditions in the state.
- Include strategies spread across the following areas:
 - policy, systems and environmental changes;
 - strategies to support and reinforce healthy behaviors (evidence-based practice and environmental approaches);
 - health systems interventions; and
 - clinic-community linkages.
- Selected interventions should have a:
 - strong prevention focus;
 - population or group focus;
 - foundation in the evidence base and justified by local data; and
 - be sustainable over time.
- Include intervention to address health disparities and achieve health equity in terms of both risk factors and health outcomes.
 - Disparities considered may be related, but not limited to racial and ethnic grouping, income, geography, sexual orientation, educational attainment,

access to health care, or other factors consistent with the Social Determinants of Health or underlying causes of poor health.
(www.cdc.gov/socialdeterminants)

Partners:

- State Health Officials
- Health Care institutions such as hospitals
- Health care providers
- Community Based Organizations
- Legislators, local elected officials
- Local boards of health
- Departments of Transportation/Insurance/Parks, Rec/Education, Agriculture, Energy, Education
- Payers
- Purchasers
- Economic Development/Planning

Format:

- Executive Summary (with endorsement by the State Health Officer and other appropriate parties)
- Overall health burden in the State – morbidity, mortality and cost data as available
 - Outline and map the current health status of the population aligned with the population health metrics document;
 - Summarize hospital community health needs assessments and incorporate any relevant state and local public health surveillance and epidemiology reports;
 - Identify specific communities and populations that may be experiencing health inequities/disparities; and
 - Identify specific communities (“hot spots”) or populations that may account for a disproportionate percentage of health care costs.
- Current state:
 - A description of major initiatives that are currently ongoing in the state to improve both health outcomes and risk-factor related behavior (such as use of tobacco, poor nutrition or lack of physical activity); and

- A description of state capacity and infrastructure in the context of the ongoing initiatives.
- The stakeholders (internal and external) that were involved in the development of the plan; including a description each stakeholder's role in the plan's development and implementation.
- The goals, objectives and new interventions that will be supported to improve health outcomes (at a minimum interventions related to tobacco, obesity and diabetes).
- Plan for implementation and governance in support of the proposed interventions, including but not limited to:
 - A necessary policy and legislative framework;
 - A sustainability model for the proposed interventions, including proposed payment models to fund the interventions;
 - A comprehensive but realistic plan to leverage and implement an interoperable health IT, data infrastructure, data analytic capacity and data sharing needs to support the Test model that maps clearly to the state's logic model;
 - Alignment of quality measures across the health care and population health segments;
 - Quality monitoring and reporting infrastructure, including electronic quality reporting;
 - Development of new population level data sets by integrating available data sources through health IT;
 - Plans for community capacity development to conduct needs assessment, certification, monitoring and support of community-based services;
 - Plans to make information about available community-based services readily available to health care providers;
 - Plans to ensure that community-service providers, including public health, where available, are an integral part of the coordinated care delivery (i.e. through PCMHs, ACOs and Bundled Payments); and
 - Plans to support improved care coordination using health IT across all entities providing interventions (including community-based service providers), such as redesigning workflows to support more effective referral management, transitions of care, and referral feedback on patient outcomes.

- An evaluation and monitoring plan that will adequately determine progress towards goals, allow for mid-course correction, measure the level of success in achieving the goals and objectives of the plan and highlight lessons learned.

Appendix 2: Health Information Technology Plan

In preparing the Model Test proposal, the state should consider both the role of health IT to enable delivery systems connectivity as well as the challenges presented by new data sharing arrangements. States may wish to review HHS' *Principles and Strategy for Accelerating Health Information Exchange (HIE)* (http://www.healthit.gov/sites/default/files/acceleratinghieprinciples_strategy.pdf), which provides both guidance about HHS' intent to promote ubiquitous use of interoperable HIE and outlines policy actions. As the State describes its HIT plan in the Governance, Policy, Infrastructure, and Technical Assistance domains in the Model Test proposal, it may wish to consider the following:

Governance

- A comprehensive, realistic plan, consistent with any existing plans, to implement an interoperable health IT and data infrastructure to support the Model Test should map clearly to the state's logic model, leverage existing assets (including those at provider, system and regional level), align with state and federally funded programs, and include strong governance.
- Governance and decision-making structures should include a process for resolving conflicts over data ownership, information sharing, and exchange between public and private stakeholders, should they arise, and expand to support the engagement of additional provider types and patients, as needed.
- The State should review and rationalize all federal IT resource investments to support a comprehensive, interoperating health and human services IT infrastructure.
- Medicaid and state enterprise IT systems should complement, support, and leverage an interoperable health IT infrastructure, creating the potential for shared public/private state-level services (e.g., provider directories, MPIs, consent registries, data transformation, normalization, and aggregation services to support event notification and other clinical alerting) and re-using health data to support administrative activities (e.g., eligibility, service authorization, care planning, quality measurement and monitoring, payment and auditing).

Quality Data Infrastructure to Support Care & Payment

- States should explore integration of standards-based public health IT systems (public health registries, surveillance, and chronic disease systems) as part of the Plan for Improving Population Health.
- States should leverage health IT (including ONC-certified health IT/EHRs, HIE, and clinical registries) to implement common quality and cost measures across

multiple provider organizations and multiple payers, and to create an infrastructure for real time quality monitoring and reporting across providers and payers.

Expanding Coordination Across the Care Continuum

- States should consider strategies to improve care coordination across the full continuum of care, including targeted interventions to support the use of interoperable, ONC-certified health IT adoption and use among long-term care and behavioral health providers, especially to support transitions in care and to reduce potentially preventable readmissions.

Patient Engagement and Transparency

- Health IT can promote patient engagement and shared decision making to ease communication between providers and patients and enables a comprehensive understanding about a patients' plan of care.
- States may wish to support open data releases especially around price transparency, access to multi-payer claims information, patient blue button, and making information available in coded, machine-readable formats to promote innovative uses of the data to support care transformation, as well as to engage patients, providers, employers, and others.

Appendix 3: Preparing a Budget Request and Narrative in Response to SF 424A

INTRODUCTION

This guidance is offered for the preparation of a budget request. Following this guidance will facilitate the review and approval of a requested budget by ensuring that the required or needed information is provided. This is to be for done for each 12 month period of the cooperative agreement project period. Applicants should be careful to only request funding for activities that will be supported by this cooperative agreement funding opportunity, State Innovation Models: Round 2 of Funding for Design and Testing Assistance. Any other grant/cooperative agreement funding provided by HHS, included previously awarded SIM funding under Round 1 (funding opportunity number CMS-1G1-12-001), should not be supplanted by this SIM Round 2 cooperative agreement program funding.

States must only request funding for activities not already funded/supported by a previous award. Awards should support separate activities and new funding should not be supplanted by prior funding. In the budget request, awardees should distinguish between activities that will be funded under this agreement and activities funded with other sources. Other funding sources include Round 1 SIM funding, other HHS agreement programs, and other federal funding sources as applicable.

Please refer to Section IV of this FOA for more information on the Budget and Budget Narrative.

A. (Personnel) Salaries and Wages

For each requested position, provide the following information: name of staff member occupying the position, if available; annual salary; percentage of time budgeted for this program; total months of salary budgeted; and total salary requested. Also, provide a justification and describe the scope of responsibility for each position, relating it to the accomplishment of program objectives.

Sample budget

Personnel Total \$ _____
SIM Cooperative Agreement \$ _____
Funding other than SIM Cooperative Agreement \$ _____
Sources of Funding _____

<u>Position Title and Name</u>	<u>Annual</u>	<u>Time</u>	<u>Months</u>	<u>Amount Requested</u>
<i>Project Coordinator Susan Taylor</i>	<i>\$45,000</i>	<i>100%</i>	<i>12 months</i>	<i>\$45,000</i>
<i>Finance Administrator John Johnson</i>	<i>\$28,500</i>	<i>50%</i>	<i>12 months</i>	<i>\$14,250</i>
<i>Outreach Supervisor (Vacant*)</i>	<i>\$27,000</i>	<i>100%</i>	<i>12 months</i>	<i>\$27,000</i>

Sample Justification

The format may vary, but the description of responsibilities should be directly related to specific program objectives.

Job Description: Project Coordinator - (Name)

This position directs the overall operation of the project; responsible for overseeing the implementation of project activities, coordination with other agencies, development of materials, provisions of in-service and training, conducting meetings; designs and directs the gathering, tabulating and interpreting of required data; responsible for overall program evaluation and for staff performance evaluation; and is the responsible authority for ensuring necessary reports/documentation are submitted to HHS. This position relates to all program objectives.

B. Fringe Benefits

Fringe benefits are usually applicable to direct salaries and wages. Provide information on the rate of fringe benefits used and the basis for their calculation. If a fringe benefit rate is not used, itemize how the fringe benefit amount is computed.

Sample Budget

	Fringe Benefits Total \$ _____
	SIM Cooperative Agreement \$ _____
	Funding other than SIM Cooperative Agreement \$ _____
	Sources of Funding _____

25% of Total salaries = Fringe Benefits

If fringe benefits are not computed by using a percentage of salaries, itemize how the amount is determined.

Example: Project Coordinator — Salary	=	\$45,000
Retirement 5% of \$45,000	=	\$2,250
FICA 7.65% of \$45,000	=	3,443
Insurance	=	2,000
Workers' Compensation	=	
	Total:	_____

C. Travel

Dollars requested in the travel category should be for **staff travel only**. Travel for consultants should be shown in the consultant category. Travel for other participants, advisory committees, review panel, etc. should be itemized in the same way specified below and placed in the “Other” category. Travel incurred through a contract should be shown in the contractual category.

In-State Travel—Provide a narrative justification describing the travel staff members will perform. List where travel will be undertaken, number of trips planned, who will be making the trip, and approximate dates. If mileage is to be paid, provide the number of miles and the cost per mile. The mileage rate cannot exceed the rate set by the General

Services Administration (GSA). If travel is by air, provide the estimated cost of airfare. If per diem/lodging is to be paid, indicate the number of days and amount of daily per diem as well as the number of nights and estimated cost of lodging. Costs for per diem/lodging cannot exceed the rates set by GSA. Include the cost of ground transportation when applicable. Please refer to the GSA website by using the following link <http://www.gsa.gov/portal/content/104877>.

Out-of-State Travel—Provide a narrative justification describing the same information requested above. Include HHS meetings, conferences, and workshops, if required by HHS. Itemize out-of-state travel in the format described above.

Sample Budget

Travel (in-State and out-of-State) Total \$ _____
 SIM Cooperative Agreement \$ _____
 Funding other than SIM Cooperative Agreement \$ _____
 Sources of Funding _____

Sample In-State Travel Budget:

<i>1 trip x 2 people x 500 miles r/t x .27/mile</i>	=	\$270
<i>2 days per diem x \$37/day x 2 people</i>	=	148
<i>1 nights lodging x \$67/night x 2 people</i>	=	134
<i>25 trips x 1 person x 300 miles avg. x .27/mile</i>	=	2,025
<i>Total</i>	=	\$ 2,577

Sample Justification

The Project Coordinator and the Outreach Supervisor will travel to (location) to attend an eligibility conference. The Project Coordinator will make an estimated 25 trips to local outreach sites to monitor program implementation. This travel furthers our efforts to accomplish specific project goals for the following reasons

Sample Out-of-State Travel Budget:

<i>1 trip x 1 person x \$500 r/t airfare</i>	=	\$500
<i>3 days per diem x \$45/day x 1 person</i>	=	135
<i>1 night's lodging x \$88/night x 1 person</i>	=	88
<i>Ground transportation 1 person</i>	=	50
<i>Total</i>	=	\$773

Sample Justification

The Project Coordinator will travel to HHS, in Atlanta, GA, to attend the HHS Conference. This travel furthers our efforts to accomplish specific project goals for the following reasons

D. Equipment

Equipment is tangible nonexpendable personal property, including exempt property, charged directly to the award having a useful life of more than one year and an acquisition cost of \$5,000 or more per unit. However, consistent with recipient policy, lower limits may be established. Technology items such as computers that do not meet the \$5,000 per unit threshold or an alternative lower limit set by recipient policy that may therefore be classified as supplies, must still be individually tagged and recorded in an equipment/technology database. This database should include any information necessary to properly identify and locate the item. For example: serial # and physical location of equipment (e.g. laptops, tablets, etc.).

Provide justification for the use of each item and relate it to specific program objectives. Maintenance or rental fees for equipment should be shown in the "Other" category. All IT equipment should be uniquely identified. Show the unit cost of each item, number needed, and total amount.

Equipment Total \$ _____
SIM Cooperative Agreement \$ _____
Funding other than SIM Cooperative Agreement \$ _____
Sources of Funding _____

<u>Item Requested</u>	<u>How Many</u>	<u>Unit Cost</u>	<u>Amount</u>
<i>[Sample Item] All-in-one Printer, Copier, and Scanner (large scale)</i>	<i>1 ea.</i>	<i>\$5,800</i>	<i>\$5,800</i>
<i>[Sample Item] X-Ray Machine</i>	<i>1 ea.</i>	<i>\$8,000</i>	<i>\$8,000</i>
			<i>Total \$13,800</i>

Sample Justification

Provide complete justification for all requested equipment, including a description of how it will be used in the program. For equipment and tools which are shared among programs, please cost allocate as appropriate. Applicants should provide a list of hardware, software and IT equipment which will be required to complete this effort. Additionally, they should provide a list of non-IT equipment which will be required to complete this effort.

E. Supplies

Supplies includes all tangible personal property with an acquisition cost of less than \$5,000 per unit or an alternative lower limit set by recipient policy. Individually list each item requested. Show the unit cost of each item, number needed, and total amount. Provide justification for each item and relate it to specific program objectives. If appropriate, General Office Supplies may be shown by an estimated amount per month times the number of months in the budget category.

Sample Budget

Supplies Total \$ _____
SIM Cooperative Agreement \$ _____
Funding other than SIM Cooperative Agreement \$ _____

Sources of Funding

Laptop Computer	=	\$1,000
Printer	=	\$200
General office supplies (pens, pencils, paper, etc.)		
12 months x \$240/year x 10 staff	=	\$2,400
Educational Pamphlets (3,000 copies @) \$1 each	=	\$3,000
Educational Videos (10 copies @ \$150 each)	=	\$1,500

Sample Justification

General office supplies will be used by staff members to carry out daily activities of the program. The education pamphlets and videos will be purchased from XXX and used to illustrate and promote safe and healthy activities. The laptop computer and printer will be used to support staff working on this project – to include compiling data for the project, creating reports, printing forms and documents. These items will be used 100% for the project.

F. Consultant/Contractual Costs

All consultant/contractual costs should include complete descriptions and cost breakdowns – for each consultant or contract. The following information, outlined below, should also be provided for each consultant or contract.

REQUIRED REPORTING INFORMATION FOR CONSULTANT HIRING

This category is appropriate when hiring an individual who gives professional advice or provides services (e.g. training, expert consultant, etc.) for a fee and who is not an employee of the grantee organization. Submit the following required information for consultants:

1. Name of Consultant: Identify the name of the consultant and describe his or her qualifications.
2. Organizational Affiliation: Identify the organization affiliation of the consultant, if applicable.
3. Nature of Services to be Rendered: Describe in outcome terms the consultation to be provided including the specific tasks to be completed and specific deliverables. A copy of the actual consultant agreement should not be sent to HHS.
4. Relevance of Service to the Project: Describe how the consultant services relate to the accomplishment of specific program objectives.
5. Number of Days of Consultation: Specify the total number of days of consultation.
6. Expected Rate of Compensation: Specify the rate of compensation for the consultant (e.g., rate per hour, rate per day). Include a budget showing other costs such as travel, per diem, and supplies.
7. Justification of expected rates: Provide a justification for the rate, including examples of typical market rates for this service in your area.

8. Method of Accountability: Describe how the progress and performance of the consultant will be monitored. Identify who is responsible for supervising the consultant agreement.

If the above information is unknown for any consultant at the time the application is submitted, the information may be submitted at a later date as a revision to the budget.

REQUIRED INFORMATION FOR CONTRACT APPROVAL

All recipients must submit to HHS the following required information for establishing a third-party contract to perform project activities.

1. Name of Contractor: Who is the contractor? Identify the name of the proposed contractor and indicate whether the contract is with an institution or organization.
2. Method of Selection: How was the contractor selected? State whether the contract is sole source or competitive bid. If an organization is the sole source for the contract, include an explanation as to why this institution is the only one able to perform contract services.
3. Period of Performance: How long is the contract period? Specify the beginning and ending dates of the contract.
4. Scope of Work: What will the contractor do? Describe in outcome terms, the specific services/tasks to be performed by the contractor as related to the accomplishment of program objectives. Deliverables should be clearly defined.
5. Method of Accountability: How will the contractor be monitored? Describe how the progress and performance of the contractor will be monitored during and on close of the contract period. Identify who will be responsible for supervising the contract.
6. Itemized Budget and Justification: Provide an itemized budget with appropriate justification. If applicable, include any indirect cost paid under the contract and the indirect cost rate used.

If the above information is unknown for any contractor at the time the application is submitted, the information may be submitted at a later date as a revision to the budget. Copies of the actual contracts should not be sent to HHS, unless specifically requested.

G. Construction (not applicable)

H. Other

This category contains items not included in the previous budget categories. Individually list each item requested and provide appropriate justification related to the program objectives.

Sample Budget

Other Total \$ _____
SIM Cooperative Agreement \$ _____
Funding other than SIM Cooperative Agreement \$ _____

Sources of Funding_____

Telephone (\$ ___ per month x ___ months x #staff)	=	<u>\$ Subtotal</u>
Postage (\$ ___ per month x ___ months x #staff)	=	<u>\$ Subtotal</u>
Printing (\$ ___ per x ___ documents)	=	<u>\$ Subtotal</u>
Equipment Rental (describe) (\$ ___ per month x ___ months)	=	<u>\$ Subtotal</u>
Internet Provider Service (\$___ per month x ___ months)	=	<u>\$ Subtotal</u>
Word Processing Software (@ \$400—specify type)	=	\$ 400

Sample Justification

Some items are self-explanatory (telephone, postage, rent) unless the unit rate or total amount requested is excessive. If the item is not self-explanatory and/or the rate is excessive, include additional justification. Example - Word Processing Software will be used to document program activities, process progress reports, etc. For printing costs, identify the types and number of copies of documents to be printed (e.g., procedure manuals, annual reports, materials for media campaign).

I. Total Direct Costs

\$ _____

Show total direct costs by listing totals of each category.

J. Indirect Costs

\$ _____

To claim indirect costs, the applicant organization must have a current approved indirect cost rate agreement established with the Cognizant Federal agency. A copy of the most recent indirect cost rate agreement must be provided with the application.

Sample Budget

The rate is ___% and is computed on the following direct cost base of \$_____.

		Personnel \$ _____
		Fringe \$ _____
		Travel \$ _____
		Supplies \$ _____
		Other \$ _____
Total \$	x	___% = Total Indirect Costs

If the applicant organization does not have an approved indirect cost rate agreement, costs normally identified as indirect costs (overhead costs) can be budgeted and identified as direct costs.

Appendix 4: Required Application Check-Off List

REQUIRED CONTENTS

A complete proposal consists of the materials organized in the sequence below. Please ensure that the project narrative is page-numbered and the following standard are completed with an electronic signature and enclosed as part of the proposal:

Standard Forms

- SF-424: Application for Federal Assistance
- SF-424A: Budget Information
- SF-424B: Assurances-Non-Construction Programs
- SF-LLL: Disclosure of Lobbying Activities
- Project Site Location Form
- Project Abstract
- Governor's Letter of Endorsement
- Letters of Support and participation from major stakeholders
- Project Narrative
- Budget Narrative
- Financial Analysis
- Operational Plan